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ANATOMY, SURGERY, AND OPHTHALMOLOGY.

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ART. I.—*The Secondary Diseases of Amputated Limbs.* By JOHN. L. NEILSON, M. D., *Resident Physician of the Commercial Hospital, Cincinnati.** (Thesis presented to the Faculty of the Medical College of Ohio, 1866.)

THIS subject embraces all the complications which prevent the employment of artificial limbs; called secondary, because they do not immediately follow the injuries inflicted by the knife, neither do they interfere with primary repair, but present themselves for treatment after the new tissue, formed at the extremity of an amputated limb, has, in a degree, become organized. It is a theme that has never been connectedly written upon as far as my limited means of information can show me, and until the civil war began in the United States, was almost wholly neglected. The study of these diseases has received an impetus from the fact that so many improvements, coincident with the great increase in the number of cripples, have been made in artificial limbs. The surgeon of the present day in the performance of an amputation and in the treatment of complications which attack such amputa-

* The observations which are the foundation of this thesis were made in the Park Military Hospital, Cincinnati, which during 1864 was a rendezvous for soldiers who desired to be measured for artificial limbs. We publish it, believing it to be highly creditable to its talented young author, and of value to the profession. G. C. B.

tions, has, beyond the mere safety of his patient, more considerations to influence his mode of procedure than in those times, quite recent, when the straight wooden peg was thought to be the *ne plus ultra* of complemental surgery. The consideration that the study of these diseases is a pathway in medical literature comparatively little explored, added to the circumstance of my having had some slight experience under established surgeons in the military hospitals of this city in the treatment of the diseases under our consideration has led me to venture to present you a thesis upon this subject.

The great majority of stumps, however perfect may be their formation, require a greater or less length of time of preparation before they become fitted to bear the constant pressure of an artificial limb. Beyond this we have those far more serious cases, and in much greater proportion, where actual disease invades the parts or there are lasting malformations, the result of pre-existing disease. For convenience of description we may classify as nearly as possible the different complications. They are, 1st. Lesions of nutrition; 2d. Nervous disorders; 3d. Disease of integumentary and muscular structures; 4th. Disease of bone: two or more of these conditions may exist at the same time. Before entering upon the particular consideration of these divisions, we will say something of the treatment, which, as we have before observed, nearly all stumps are subjected to, in a greater or less degree, before they can be accurately measured for the artificial member.

Tenderness of the newly-formed tissues and some expansion of the extremity of the amputated limb always exist. The perfection of the stump is often a mere question of time. Where there is extreme and persistent tenderness, astringent and stimulating lotions are useful, at the same time intermitting the wearing of the limb. In all cases the surface of the stump should be thoroughly washed and rubbed at least once a day; a neglect to keep the parts clean often causes much trouble. The absorption of material effused by inflammation will be hastened by keeping the extremity firmly bandaged, we will thus also assist in the proper condensation and contraction of the tissues.

Modern improvements have to a great extent relieved the stump from direct pressure, but even when there is the most perfect adjustment, there is a certain degree of pain and discomfort in the early use of the limb caused by the forcing down of the extremity of the bone and the retraction of the soft tissues.

We now proceed immediately to the consideration of the first classification, viz: Lesions of nutrition.

The conditions which are presented in this division are called

sthenic and asthenic. In both, however, there is neither destruction of parts nor want of symmetry; the stump is perfect, and the patient may have worn an artificial limb at one time with great comfort, but he presents himself for treatment with an enlarged and clubbed stump which prevents the adjustment of his limb.

The sthenic cases are true examples of hyper-nutrition. There is nothing abnormal beyond the enlargement and perhaps an increased vascularity of the integuments. It occurs in muscular and plethoric individuals, in whom there is great vascular tension, who have apoplectic tendencies as evidenced by the short, thick neck, the hard, full pulse, brawny muscle, and congestion of the integumentary capillaries. As in all cases of deviations from common nutrition, the causes are not well made out. We may say with Paget, that the abnormal growth (which in fact is only abnormal as to size) is the result of an unusual accumulation of nutritive material in the blood, or that there is some cause which invites and determines to the parts a larger quantity of blood; we have the evidence of our senses that there is an actual increase of the normal tissues, and there is an augmented afflux of healthy blood. After the subsidence of active inflammation, the result of direct injury, we will find this condition supervening. It sometimes appears to have been caused by long-continued irritation of ligatures, splinters of bone, even the pressure of an artificial limb. It will occur idiopathically. When once established but little can be done. Iodide of potassium and ammonium, both internally and externally, may be tried, together with bandaging. The treatment of cases which are traumatic will be given when speaking of direct injuries.

But the asthenic forms of enlargement must not be confounded with the state just described. It is the antipode of the condition we have called sthenic; it is a disease of broken-down anæmic constitutions, presenting itself in those patients who, after great physical privations and sufferings, have added to these depressing agencies the shock of a capital operation. By long marches, insufficient and bad quality of food, exposure and intemperance, they have a condition of system, if not actually scorbutic, at least intensely anæmic, and they, perhaps passing safely through the reparative processes, present themselves afterward with a stump, perfect in its parts, but abnormally enlarged. They are types of anæmia, the mucous membranes of the lips and eyelids present an extreme pallor; if not emaciated they are puffy; integument white and sodden, with prominence of the sebaceous glands upon the face; covered with unhealthy eruptions; their digestive and assimilative processes very imperfectly performed; tongue either glazed and

pale, or red and rough; gums tender; sometimes there is diarrhœa. The stump becomes enlarged from venous stasis, the result of debility; it perhaps has an erysipelatous redness; the cicatrix is of a livid color, and about its edges are frequently found small, obstinate, and irritable ulcers, especially if the patient shall have worn his limb constantly and has been uncleanly.

Nothing can be done with these cases until their general health is thoroughly re-established. The use of iron, tonics and nutritious food, the observance of perfect cleanliness and temperance, regulation of the secretions with the avoidance of everything which tends to derange digestion, are the main points to be considered in the treatment. If there are scorbutic tendencies, fresh meat and vegetables, with acid fruits and wines are indicated, while the citrate of iron and potassa, or the citrate of iron alone, dissolved in madeira, claret, or catawba, will be found especially useful. When there are manifest tuberculous symptoms, the special preparations of iron, as the syrup of the iodide, the bromide, the hypophosphites, together with cod-liver oil may be given with advantage. Very frequently, the anæmia is the result of chronic malarial poisoning, and the use of quinia will be indispensable. The cachexia produced by the venereal poison will, of course, be met by its appropriate remedies. The ulcers which have formed may be treated with mild stimulating lotions, and if they are extremely indolent, or give any evidence of spreading, destroy them at once with concentrated nitric acid, for they are exceedingly prone to produce extensive ulceration. In all cases, the limb should be bathed once a day in warm castile-soap suds, after which support may be given to the relaxed vessels by applying a firm bandage. When there are excessive dragging sensations, they may be relieved by keeping the limb elevated and at rest.

Before leaving this division of our subject we will speak of inflammation, the result of direct violence. Patients are exceedingly liable to these injuries when they first begin to go about upon crutches or to use an artificial limb. These injuries vary from mere bruises, to the most extensive laceration of tissues. I have seen a stump, amputated at the lower third and recently healed, burst open as it were like a melon, from an inconsiderable fall. Again, there may be no appreciable lesion of the integuments and you put the patient to bed and apply treatment or not, and in ten or twelve hours he will begin to complain of pain and tension, there will be slight redness and some swelling, and in the course of time a large collection of pus will be developed. Exfoliation of the extremity of the bone will sometimes follow these injuries. The main indication in these cases is to combat inflammation and relieve pain.

The patient should be placed in bed, the limb slightly elevated, and water-dressings applied. If there are foreign matters in the wound remove them, and if there is extensive laceration, stitches may be necessary. Perchloride of iron may be applied if there is much oozing. If inflammation threatens, leeches may be applied just above the inflamed part. Pain should be relieved by full doses of morphia. An active antiphlogistic treatment will be required when the patient is robust. If pus should form it should be early evacuated. Long after the occurrence of these injuries, especially where there has been neither laceration of tissue nor formation of abscess, the stump remains perfectly indurated and enlarged. Alteratives and evacuants should be freely employed, both externally and internally, in conjunction with firm bandaging.

Neuralgia.—The stump in these cases may be well formed and covered with healthy cuticle, the process of repair may have long been completed when the patient begins to have darting, neuralgic pains, starting apparently from the extremity, and passing up the limb, pain which is sometimes caused by pressure alone, but far more often is constant and increased by contact. The sufferings of patients thus afflicted are extreme, they have very few moments of rest, and only snatch a few broken moments of sleep. The pain in some cases is most intolerable. The intensity of such suffering must appeal to and stimulate every energy of the physician or surgeon in the employment of his remedies, but very often the most powerful and carefully directed efforts are impotent, not only to cure, but even to alleviate. The general health of the patient is good; there is no appreciable vascular disturbance, nothing in fact presents us abnormal symptoms except the local injury. Like those peculiar sensations which patients have and which they refer to a limb long since amputated, the cause can only be obscurely referred to as a disordered nerve action. As the pathological condition is obscure, so is the treatment uncertain. There is one theory, however, which will, in a degree, stand the test of practical criticism, viz: that some nerve is engaged in the cicatrizing tissues. This hypothesis, in some cases, is supported by facts, for we find as the cicatrix becomes more indurated and hardened, the pain increases, it is augmented by pressure upon particular points, and is sometimes removed by an operation which loosens up the affected portion; but there are cases which seem to be purely the result of altered nerve action, where no injury has been inflicted, where no medicinal agent has other than a temporary effect, and where amputation may be performed again and again, and the pain returns, baffling every art of the profession. A certain number of cases are cured by amputation, while others are only relieved until the tissues

begin to cicatrize, like breaking down the bridge after the enemy has passed over, since the disease, apparently a local affection, has become constitutional. Amputation is the only radical cure, and when it fails, no treatment will avail. There are cases which are caused by the irritation of spicula of bone, pieces of lead, clothing or other foreign bodies, where the removal of the particle gives permanent relief. As a palliative measure, excision of a portion of the affected nerve will often answer. Blisters over the track of the nerve are of little value. Every form of anodyne has been used with varying, but in all cases, with only temporary success. The hypo-dermic injections of solutions of morphia will be found to be the most valuable palliative the profession possesses. We can look in some cases where the cause has been traumatic, for a gradual but permanent disappearance of the pain: out of six cases which have come under my observation, one, who had pain up the leg and thigh on the external surface, gradually lost his pain after being in the hospital over three months; he had suffered in all some nine months. The apparent cause was a flesh wound on the outer side of the ankle of the affected side. No special plan of treatment was pursued, the injections of morphia excepted.

I have seen a soldier who suffered from neuralgic pains in the distribution of the portia dura, and in the extremity of an amputated thigh, who was likewise laboring under visceral enlargements, the result of chronic malarial poisoning, who was discharged from hospital completely relieved of both pains by the administration of large doses of assafœtida and quiniæ in equal quantities. This case can not be strictly classified under this division, but will serve as a useful indication of the treatment which will sometimes be required.

(*To be continued.*)

ART. II.—*Papers on the Surgical Diseases of Children.* By M. P. GUERSANT, *Chirurgien honoraire de l' Hopital Dès Enfants Malades; Membre honoraire de la Societe de Chirurgie. Translated from the French by* J. C. REEVE, M. D., *Dayton, Ohio.*

[*Continued from the February number.*]

HERNIA.

Abdominal hernia, which is characterized by the escape of some of the viscera of the abdomen through natural openings, occurs as frequently during infancy and childhood as at other ages, and especially during the first months of life. We have met with it oftener in little boys than in little girls.

Some facts would justify us in considering this affection hereditary; but

without resorting to this view, we may notice several especial conditions of infancy which explain the development of a considerable number of cases. These conditions are to be found, on the one hand, in the state of the openings, which are less tense and not so perfectly closed as in the adult, and on the other, in the unconstrained manner in which children make all their first efforts; in truth, the infant, even of some months old, does not restrain its cries any more than its desire to evacuate its bowels, and it exerts all its powers, often indeed exaggerating them to the highest degree. These we look upon as the principal causes of hernia in the infant, not however because it is necessary to exclude, in their case, the same causes which act in the adult, but they act less frequently in infancy, and are at the same time less appreciable.

The parts constituting hernia are not always the same; we have seen a hernia formed by the mesentery, the small intestine, the large intestine, the ileo-cœcal appendix; we have seen, in three little girls, a hernia formed by the ovary descending through the inguinal canal into the labium; and the other organs of the abdomen may also present themselves. In general, all these herniæ are enveloped in a sac formed of the peritoneum, except in the case of congenital inguinal hernia in which the displaced organs descend directly into the tunica vaginalis.

The openings by which herniæ of children occur are, first, in the youngest or immediately after birth, the umbilical opening and separation of the linea alba; and afterward, still however sometimes just after birth, the inguinal ring.

The symptoms are in general almost the same as in the adult.

We will consider successively umbilical hernia, next hernia of the linea alba, and then inguinal hernia.

Umbilical hernia may be observed at birth or a few days afterward; its cause may be the crying of the child, and sometimes want of attention in supporting the abdomen with the binder; sometimes also debility and weakness of the infant may give rise to it.

It is easily recognized; upon examining the umbilicus there is found at the opening, or just above or below it, a tumor without any change of color in the skin, about the size of a small nut, easily reduced and communicating to the finger which presses it a sensation of gurgling. It disappears under pressure and shows itself again as soon as we remove the finger; sometimes the child is subject to colic; but what is especially to be remarked is, that the tumor augments in size during crying.

When the tumor is of small size steady support of the abdomen will suffice to cause the umbilical opening to decrease in size and the tumor promptly to disappear, especially if the infant gains in flesh and strength. But more frequently it tends to increase in volume, and we are obliged to retain it by means of a bandage. Many kinds have been invented, but most frequently these bandages slip about, do not retain the hernia, and are entirely insufficient to meet the end for which they were designed. We believe we are justified by what experience has taught us in rejecting entirely all spring band-

ages, the simplest as well as the more complex; the belts, with balls or pads fixed in the middle, are no more serviceable. We believe the best bandage is formed of adhesive plaster; we prefer to all others one made by fixing a simple hemisphere of yellow wax or of vulcanized rubber, to form the pad, upon a strip of adhesive plaster about an inch and a half wide, and long enough to go one and a half times around the body; it adheres to the skin and retains the hernia perfectly. This simple bandage, which appears to us superior to all others, and which is always at hand, should be prepared with care. The wax should be softened by heat and shaped into a sort of marble, which is cut in two to form the hemisphere; it should be of a size corresponding to the opening, always larger than this, so as to exert compression upon it and not enter into it, for this would be rather injurious than useful. This hemispherical pad, covered with fine linen, should be placed upon the umbilical ring, its convexity downward and its flat surface in connection with the adhesive strap; above this strap several turns with a roller may be made around the abdomen. Before applying this bandage it is a good plan to powder the parts with which the plaster will come in contact with rice or starch powder; it prevents that erythematous action to which the plaster may otherwise give rise. This kind of bandage should be allowed to remain in place three or four days together; when it is to be renewed, another wax pad and adhesive plaster should be prepared beforehand, and no interval allowed between the removal of the old one and the application of the new, during which the intestine may escape and all that has been gained thus lost. If the skin of the infant is irritable and becomes red by the use of the adhesive plaster, we must content ourselves with the use of a linen bandage applied circularly around the body; but this kind of bandage has the inconvenience of slipping and becoming displaced and does not maintain its position like adhesive plaster.*

Umbilical hernia is cured by this bandage carefully applied in from six weeks to two months.

We have never even had under consideration a resort to a radical cure of this hernia by the ligature, after reducing the contents of the sac; whether the ligature be single or multiple, used with or without tension, it has never inspired us with a feeling of security, for it is dangerous.

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* Long before reading the author's remarks, and after constant disappointment with other means, we had fixed upon a plan of treating umbilical hernia in infants, which has never failed thus far, and which we do not think we shall ever abandon, because it is both simple and effectual. Instead of making "a sort of marble" of yellow wax for a pad, we resort to the marble itself. The common brown marble can be readily split with a hammer and blunt knife into two hemispheres, the convex side is smooth and occasions no irritation even if not covered with lint, as we were careful to do at first, while the split surface adheres well to adhesive plaster, a piece of which three or four inches square is laid over it and the umbilical region, while the whole is secured by the common bellyband of the child. Contrary to the practice of the author, we never remove this bandage; if it falls off the mother is directed to re-apply it immediately with a new piece of plaster left for the purpose.—Trans.

I have never seen umbilical hernia strangulated in children. I have seen cases lightly obstructed which became reducible after the application of cataplasms.

Hernia of the linea alba is formed by a separation, sometimes considerable, of this line, either above or below the umbilicus. It forms a tumor of oval form more or less elongated; it is fluctuating and disappears upon pressure. In these cases well-applied ventral bandages are useful.

Inguinal hernia in infants, and especially in little boys, is very common; it may be simple or double.

In children, as in adults, the symptoms are local and general; the latter consist in attacks of colic more or less marked, and sometimes repeated vomiting. The local symptoms are the same as those observed in adults; there is in the region of the groin a tumor more or less voluminous, sometimes very small, perhaps as large as a nut, sometimes very much larger; always without change of color of the skin, fluctuating and easily reducible, with gurgling; generally a slight pressure sufficing to return the intestine through the inguinal ring.

These symptoms often exist upon the right and left side at the same time, for it is not rare to see two inguinal herniæ in the same patient.

The contained parts are generally a small or large intestine with or without mesentery. We found the ileo-cœcal appendix upon one occasion in operating upon a strangulated hernia in a child seven or eight years old, which died afterward of peritonitis.

Inguinal hernia in children may be confounded with hydrocele, a cyst of the cord, a descending testicle, a tumor of the testicle, and in little girls with a descent of the ovary. The first case of the latter kind which we met with was not understood; we had under our care in the children's hospital, in 1851, a girl of eleven years of age, who had a small tumor below and upon the internal face of the left labium, which was taken for a cyst by me, by M. Broca, and by other colleagues; it had been there since the patient was one year old. Believing it to be a small encysted tumor, and as it had become very painful and interfered with walking, we proceeded to remove it. After having exposed it by an incision, finding it suspended by a prolongation, a ligature was placed around the pedicle and it was divided; the tumor proved to be an ovary. The child died two days afterward of peritonitis originating from the ligament which formed the pedicle. We have avoided a similar error in two other little girls who have come under our observation since then; we have ascertained that these herniæ form a small tumor which is situated within the greater labium, that this tumor rolls about like a cyst, that on pressing it it glides between the fingers, it appears held when an attempt is made to draw it downward, and mounts upward when the hold is relaxed, as a cyst of the cord rises again after being pulled downward. In both cases the tumor could not be returned into the abdomen. [Two cases of this kind, occurring in young women, are reported in the last edition of Tanner's Practice, p. 652.]—*Tr.*

Hernia should not be confounded with hydrocele, simple or encysted. In

the simple hydrocele there is appreciable fluctuation of a liquid and not of a gas; often there is reduction, but only in that form of hydrocele which communicates with the abdomen; finally, transparency can be discovered. Encysted hydrocele forms a small transparent tumor, circumscribed to the course of the cord, which rises and descends as the testicle is drawn downward and released.

It is very important to distinguish a hernia from a testicle descending through the inguinal canal; this descent usually occurs toward the seventh month of intra-uterine life, but it often takes place at the moment of birth, or sometimes at a longer or shorter time afterward. When it is a testicle descending, we learn from the parents, or by a personal examination, that the scrotum in the corresponding side contains nothing, that the body presenting itself at the ring is of rounded form, more or less firm, returning by pressure without gurgling. You can also, by taking the tumor in the fingers and drawing it downward ascertain that it is retained by a pedicle, which is the cord; that it can be returned entirely into the abdomen to reappear on coughing, or perhaps when the child walks; this tumor is not painful when returned, while when again in the ring the pressure excited upon it sometimes occasions suffering.

In the child we have also to distinguish between congenital and accidental hernia; in the former, the hernia occurs in the tunica vaginalis, in the latter there is a sac independent of the tunica vaginalis.

In general inguinal hernia is formed by the mesentery in the intestine; abandoned to itself it tends to increase in size and may become enormous. Children may have a hernia without experiencing any symptoms; more often, however, they have attacks of colic, especially when the hernia is down or but incompletely retained. It may become inflamed from the pressure of bandages; there will then be pain, and in such a case, some baths, cataplasms, and the temporary withdrawal of the bandage, if the child wears one, will suffice to allay the symptoms.

The hernia may also in children, as in adults, become obstructed or strangulated. Obstruction is characterized by the presence of fœcal matter in the intestine. This accident which is most frequently met with in old persons who can not reduce the hernia, is also seen in feeble and delicate children; several surgeons, among others M. Goyrand, have observed cases of this kind. The symptoms of obstruction are an increase of volume and weight of the tumor, its consistence being soft and doughy; there are borborygmi and eructations; the skin over the tumor is of normal color; the belly is inflated without being painful; sometimes there is nausea or even vomiting. Emollients applied to the hernia with injections generally suffice to effect the cure which is brought about by evacuations. The taxis and even a light purgative are indicated.

Strangulation of a hernia occurs much less frequently in children than in adults or old persons, but we have met with it often, even in infants only a few weeks old. We have seen in these cases of strangulation all the symptoms which occur in the adult; hardness and tension of the tumor; the belly

hard and painful; there are eructations and vomiting; the patient vomits first the contents of the stomach, then follow matters ascending from the bowels, he expels fœcal matter by vomiting, while little or none at all escapes per anum. In a word, we see in children the same symptoms as in adults and the aged. The tumor may inflame, perforation occur and an artificial anus be more or less rapidly established; at the same time, the countenance changes, the pulse, frequent from the beginning, becomes feeble and death ensues.

These grave terminations are observed less frequently, however, than in adults, and often the hernia returns spontaneously, or at least becomes more readily reducible. In truth, frequently as we have been called to strangulated hernia in children, we have generally been successful with the taxis, and have only failed in very rare instances.

When about to apply the taxis, especially with very young children, we place the little patient on an inclined plane, in such a manner as to depress the head and the trunk and elevate the pelvis; we follow the directions laid down for the taxis in adults; we press the tumor toward the ring in such a manner as to make the superior portion enter first and the next afterward. We follow up this plan but a very short time without chloroform; but as soon as we find it useless, which often happens, because children by bearing down and straining oppose reduction, we prescribe the application of a poultice upon the tumor, order a bath, and immediately have recourse to anæsthesia in order to be able to apply the taxis without being opposed by the cries and the efforts of the patient; we have in this way almost always succeeded in effecting reduction.

When reduction is impossible, we must resort to the operation, and its success is certain in proportion to the shortness of the time during which the taxis has been employed, and since strangulation occurred. At the end of eight or ten hours from the beginning of the symptoms, we should employ the bath, the taxis with chloroform, and not shrink from the operation if the hernia be not reduced. Pott lost a child of two days with strangulated hernia; Gooch saw a child of six weeks die; Dupuytren operated upon an infant of twenty days; M. Goyrand operated on one of four months which recovered; Roux operated on one of two years. [Lawrence operated upon an infant under two months of age; Curling upon one of nine weeks; Solly upon one of fifteen months; Fergusson upon one of seventeen days; Hawkins one of seven weeks; Luke one of three months; Stanly one of seven months; Long one of fourteen months; Adams, of Dublin, one of eighteen months. The operations of Hawkins, Long, Stanly and Adams were successful.]—*Tr.*

We have been called to many cases of strangulated hernia, and have generally been fortunate enough to reduce them, with the aid of chloroform, even in infants of six weeks or two months. Rarely have we been obliged to resort to the operation, and the three cases in which we did resort to it proved unsuccessful.

The precautions to be observed in the operative proceedings should be the same as in the case of adults; the consecutive treatment is also very important

and should be more scrupulous on account of the tender age of the patients. We have to guard against peritonitis.

We ought to add that the accidents which we have just indicated, are very rare in children, and that in general, the earlier we are consulted the better chance there is of seeing the hernia promptly cured by the constant application of well designed bandages, and especially if the children gain rapidly in flesh and strength, however emaciated they may have been. Those treated during the early months of life may be cured by the methodical application of bandages in four or five months. Those of a year old and more may be cured by wearing the bandages for a year. But when they are more advanced in life, the treatment should be continued several years, and then be only gradually discontinued. At first the bandages are to be worn night and day, but upon dispensing with them, let it be at first during the night, the patient resuming them during the day.

In general we apply the bandages as soon as consulted, at first light India-rubber ones, with an air pad for infants; but for children of six months to a year we prefer spring trusses, made light and well covered. It is above all indispensable for very young children to have two instruments on account of frequent wetting and soiling, which makes a daily change necessary.

Operations for Cataract.

A writer in the *British and Foreign Medico-Chirurgical Review* for January, 1866, in an analysis of papers published in the fourth volume of the *Ophthalmic Hospital Reports*, thus notices the methods of operating for cataract which are now becoming the most favorite:

"The great changes lately introduced, which are being rapidly substituted for the old methods, are, theoretically, rather in the direction of linear extraction than of the older operations proper or solution—that is to say, the cataract is, in one way or another, extracted or removed altogether, and by a linear opening—a section at any rate, much smaller than that of half the circumference of the cornea required for extraction proper. By this means the many and great risks of the last-mentioned operations seem to be avoided. Nevertheless, quite original notions have prevailed, and perhaps now the most usual substitute for extraction is the operation of "spooning out" the cataract after the performance of an iridectomy. Unfortunately, no two operators are now agreed in their practice; and when we inquired lately of a friend just returned from Germany, on a tour of the principal eye hospitals, what the German ophthalmologists were doing for cataract, he said, 'They are all at sixes and sevens, as you are in England.' Extraction and solution and linear extraction are, however, not quite abandoned, they are only generally superseded; and, in addition to the different plans for iridectomizing and spooning out cataracts, we have to consider, in relation to the modern surgical treatment of cataract, the "suction" instruments and the modes in which they are

used. . . . Now we are threatened with as many varieties of cataract spoons, as of late years we have had of knives—that is to say, each operator has one peculiar to himself. An iridectomy is first made, now generally at the time of the operation for the removal of the lens, as was proposed by Waldan (Schuft), who invented the "spoons" and the method of their use. But some have preferred to iridectomize as a preliminary operation performed some few weeks before that for the removal of the lens. We must well consider this new method of removing senile cataracts, for Mr. Critchett informs us he has lately adopted it exclusively, and Mr. Bowman says that in this operation the average of success 'has uniformly been higher than that of the flap operation in my hands.' It is of the greatest advantage that chloroform can be administered without one fear of the subsequent retching that may occur. As to the operation itself, the various precautions and details are so minute and vary so much in the hands of different operators, that they can not be given and compared here."

Dr. Mooren makes a previous iridectomy, and after five or six weeks, performs the ordinary flap extraction. Professor Jacobson combines the ordinary flap operation with an iridectomy at the same time. Professor Schuft performs a modified linear extraction and employs a peculiar form of spoon. Extraordinary success is claimed for each of these methods, but as Mr. Critchett remarks: "Thus suddenly appeared three new methods of operating for cataract, bearing the names of their several champions—the method of Mooren, that of Jacobson, and that of Schuft (Waldan); but justice compels me state that these gentlemen lighted their tapers at the torch of their great master, Professor Graefe. Each of these methods had been previously suggested and practiced by him, but only in exceptional cases instead of as a general rule." Mr. Critchett is himself in favor of the "scoop extraction," and states that during the past year he has exclusively performed this operation. Mr. Bowman also performs the same operation slightly modified, and as great weight is justly attached to whatever emanates from his pen we give a description of his mode of operating as published in the fourth volume of the *Ophthalmic Hospital Reports*.

(*To be continued.*)

Prof. McGuire, in a Clinical Lecture on Gunshot Wounds of Joints, published in the *Richmond Medical Journal*, thus describes Stonewall Jackson's first wound:

"From many cases which I now call to mind, I select the one which happened to General Jackson at the first battle of Manassas. I do this, because anything connected with this distinguished General is full of interest. When

he made the celebrated charge with his brigade, which turned the fortune of the day, he raised his left hand above his head to encourage the troops, and while in this position, the middle finger of the hand was struck just below the articulation between the first and second phalanges. The ball struck the finger a little to one side, broke it, and carried off a small piece of the bone. The upper fragment was split longitudinally and the articulation opened, but the joint was not otherwise injured. He remained upon the field, wounded as he was, till the fight was over, and then wanted to take part in the pursuit, but was peremptorily ordered back to the hospital by the General commanding. On his way to the rear the wound pained him so much, that he stopped at the first hospital he came to, and the surgeon there proposed to cut the finger off; but while the doctor looked for his instruments, and for a moment turned his back, the General silently mounted his horse, rode off, and soon afterward found me. I was busily engaged with the wounded, but when I saw him coming, I left them and asked if he was seriously hurt. "No," he answered, "not half as badly as many here, and I will wait." And he forthwith sat down on the bank of a little stream near by, and positively declined any assistance until "his turn came." We compromised, however, and he agreed to let me attend to him, after I had finished the case I was dressing when he arrived. I determined to save the finger if possible, and placed a splint along the palmar surface to support the fragments, retained it in position by a strip or two of adhesive plaster, covered the wound with lint, and told him to keep it wet with cold water. He carefully followed this advice. I think he had a fancy for this kind of hydropathic treatment, and I have frequently seen him occupied, for several hours, pouring cup after cup of water over his hand, with that patience and perseverence for which he was so remarkable. Passive motion was instituted about the twentieth day, and carefully continued. The motion of the joint improved for several months, after the wound had healed, and in the end, the deformity was very trifling.

"During the treatment, the hand was kept elevated and confined in a sling, and when the use of this was discontinued, and the hand permitted to hang down, there was, of course, gravitation of blood toward it. Under the circumstances, you would expect this. In consequence of it, however, the hand was sometimes swollen and painful, and to remedy this, he often held it above his head for some moments. He did this so frequently that it became at length a habit, and was continued, especially when he was abstracted, after all necessity for it had ceased. I have seen it stated, somewhere, that, whenever during a battle, his hand was thus raised, he was engaged in prayer; but I think the explanation I have given is the correct one. I believe he was the truest and most consistent Christian I have ever known, but I don't believe he prayed much while he was fighting."

Diagnosis of Injuries at or near the Hip-joint.

Mr. Jonathan Hutchinson, F.R.C.S., in a Lecture published in the *London Times and Gazette*, Feb. 24, makes the following general remarks on this important subject:

"I do not propose to enter here upon any systematic description of the different forms of dislocation or fractures, but to make a few general remarks, applicable to cases in which doubt is felt. In the first place, let me urge, as I have often done before, that in difficult cases of injuries near the joints the surgeon should always allow himself the advantage of chloroform. Examination is so much facilitated by this agent that unless a clear judgment can be come to without its use, it ought never to be neglected. Many an unfortunate mistake would be avoided were this rule of practice adopted. Not only does it aid in diagnosis, but it often gives most material assistance in the treatment also. Secondly, let me caution you not to be misled by the patient's statement as to what he can accomplish with the injured limb, into the belief that he has sustained no serious injury. Persons with dislocations at the hip are often able to lift the limb from the bed (in two of our recent cases this could be done) and now and then they are even able to walk. * Especially we may often note, that under the partial influence of chloroform, when sensation is diminished, but the muscles not paralyzed, a patient will often use a dislocated limb very freely. Thirdly, as a rule, in dislocations, the range of motion is diminished, and in fractures it is increased. If in the case of an injury near the hip, you find the motion much increased, so that you can bend the limb in abnormal positions, you may be almost certain that it is a fracture with which you have to *deal*. In many cases, however, the converse of this is not true, and you may have much diminished motion although the bone is broken. This may occur either from the patient's muscular resistance, or more frequently from impaction of the fragments. Fourthly, do not expect your cases to conform with exactness to the description given in books. The majority will do so, but a large minority are cases which deviate in one or other direction from the orthodox types of injury. In order to avoid risk of error, you must therefore let each case have its own peculiarities, and very carefully investigate them all. Have the patient stripped and examine both hips at once. Make your examination systematic and point by point, compare the relations of the bones on the two sides. Always use a measuring tape, but do not trust it too far; unless its results are definite it may easily mislead, for accurate measurements are difficult to make, especially in reference to the lower extremity, and the eye

* Sedillot, of Strasburg, has recorded two cases proving that patients suffering from dislocations into the thyroid foramen can occasionally walk well. One man did duty for years as a soldier, with an unreduced dislocation of this kind, and autopsy at length verified the diagnosis. In another case, a man walked about (lame slightly), for three days before it was diagnoseded. Ruction was then effected.

is often more trustworthy than the tape. Fifthly, take into due consideration the age of your patient and the conditions of the accident. Dislocations may occur at the hip from the earliest ages of childhood; they are tolerably common in adult life, and very rare in old persons. Separation of the epiphysis can only occur under the age of 21. Fractures of the neck of the femur are very common in old age, but may happen at any period. Dislocations are caused by indirect violence, severe twists of the limb, etc., never by direct blows. Fractures of the neck are common both from direct and indirect violence. Impacted fractures can only result from direct violence, *i. e.*, blows or falls on the trochanter. Sixthly, remember that many cases of fracture through the cervix are attended by impaction, and that the unkindest thing you can do for your patient under such circumstances is to make a correct diagnosis at the expense of separation of the fragments. Whenever impaction is suspected, examine very cautiously. Seventhly, remember that although eversion is the rule in fracture of the cervix, inversion is sometimes met with. With inversion, the case might be thought to resemble a dislocation upon the dorsum."

The following report of a novel method of reducing the head of a luxated femur we find in the "*Maryland Medical Recorder*, Oct. 1831."* We re-publish it as a matter of historical interest in Ohio Surgery, and we append to it an account of Afghanistan native surgery, taken from the "*Medico-Chirurgical Review*," Oct. 1864, p. 412. Both strikingly illustrate the surgical power of fluids even when administered in modes somewhat different.

This luxation occurred about the 1st of October, 1830, and was reduced on the 15th of April, 1831, a period of 6½ months.

John Scott, aged 30, of Jefferson county, Ohio, of temperate habits, being at a raising (building a log house, a sort of western frolic), about the 1st of October, 1830, was caught under a falling log, which, passing over him, bruised the left side of the pelvis, crushed him under it, and dislocated the right os femoris backward, the head resting on the dorsum of the ilium, perhaps. A physician was called, with sufficient force he made extension and counter-extension until he and the assistants thought they heard the bone snap into the acetabulum, and all believed it replaced.

The man was placed on the floor, on a bed, etc., etc., shortly after the bone slipped out apparently. It was again drawn in; this is said to have happened often. The attendant surgeon then applied a box, with a part extending to the axilla, kept the limb fixed by a band round the ankle and foot, fastened to a staple in the floor, and continued this treatment for six weeks. At the end of this time, he informed his patient, on finding the limb imperfect, that there was fracture of the neck of the thigh bone.

In February, 1831, two other respectable and experienced surgeons were consulted; they agreed, in opinion, with the original attendant.

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*Reported by Dr. Benjamin Dickson, of Steubenville, Ohio.

About two weeks after (Feb. 26th, 1831), I was called to visit the patient. I found the limb about half an inch shorter than the other, the toes fell somewhat downward, the foot and knee turned very little inward, the limb rotated freely, but the great trochanter described a wider arch than in cases of fracture of the neck of the femur, either within or without the capsular ligament.

I pronounced the case dislocation, disagreeing with those in attendance. A professional brother, who called accidentally, concurred in my opinion. On further examination, we were convinced that from efforts to reduce the bone, the head of the femur had been drawn into the ischiatic notch.

The man being informed that his case was merely dislocation, insisted that efforts to reduce it should be employed. We endeavored to convince him that new adhesions had taken place, that it was impossible, from lapse of time, that no reduction was on record, etc., etc. He remarked, "It is strange if you can not use force enough to replace a bone that has been displaced by force; I would rather die on your hands than limp through life." After repeated solicitations pulleys were applied, bleeding, tart. ant., etc., etc., given and efforts used to reduce, for about an hour without effect. He left town next day.

On the 15th of April, 1831, Scott called on George W. Duffield, of Annapolis, Jefferson county, Ohio. I shall repeat nearly the Doctor's words, "The man told me that I must try to put in his limb, that he would suffer anything, he would rather die than remain lame through life. Having succeeded in two cases of long standing before, I told him I would undertake it on the 18th, and directed him to get drunk, and keep so until that time, previous to which I prepared a windlass, with which, having extended and relaxed the muscles, until I believed contractility exhausted, I removed the apparatus, put the ankle into the hands of two strong men to extend, the body being fixed, and placed one at the knee to press it outward; after several unsuccessful attempts, the patient drinking spirits freely nearly all the time, I placed a third person at the ankle, while I gave directions. When the limb was sufficiently extended, I suddenly threw my whole weight on the inside of the knee, pressing it outward, and the head of the bone slipped into the socket."

The gluteal muscles were considerably wasted, and have not yet recovered their energy, the man walks with a cane, the limb straight.

Doctor Duffield says he has restored dislocations of the hip joint of long standing, in two other persons, viz: A. Eusley, aged 50, very intemperate, after four months—and William Campbell, aged 60, after two months.

A traveler in Afghanistan gives us a curious insight into native surgery:

"The Afghans, from their rough and hardy mode of life, acquire by experience a number of very practical, though to be sure, uncouth methods of righting themselves, their horses and cattle, that may suffer from accidents.

Their operations for the reduction of dislocation in the human subject, are most original, and if report speaks at all truly, equally successful.

For a dislocation of the thigh, the unfortunate patient is sweated for three days in a dark room, the atmosphere of which is heated by fires kept burning night and day; and the effects produced by this high temperature are increased by drenching the patient with copious draughts of warm rice-water or thin gruel. During the interval that this treatment is enforced on the patient, a fat bullock or buffalo is tied up and fed *ad libitum* with chapped straw flavored with salt, but is rigidly denied a drop of water. On the third day the patient is made to ride the bullock astride, a felt alone intervening between himself and the animal's hide; his feet are next drawn down and fastened tightly under the animal's belly by cords passing round the ankles. All these preliminaries arranged, the animal is then led out to water, and drinks so greedily and inordinately that its belly swells to nearly double its former size; the traction produced by this on the dislocated limb is sufficient to bring the wandering bone back to its socket."

In the *London Lancet* (Feb. 17), is published a letter from Dr. Dorat, of Santa Anna, Central America, in which is described a novel suture. "I will mention a curious case of native surgery I witnessed a short time ago. The patient had received a severe stab in the abdomen, from which protruded about half a yard of intestine and a portion of omentum, the former having a longitudinal slit about three inches long. On my arrival I found an Indian *medico* had sewed up the wounded gut with *the nippers of a large ant*. The insect, which is very savage, was taken by the body and its head presented to the united lips of the wound, which it bit and held fast. The operator then, by a pinch of the fingers, killed the ant (nipping off its body and ?) leaving its head fixed to the gut. Another and another ant thus applied, to the number of a dozen or fifteen, effected this singular suture. The gut was then replaced, and no inflammation ensuing, the man recovered speedily. This curious practice is said to be usual in this part of Central America." The above suture throws Vidal's *serre-fine* into the shade.

We learn from a late English paper that the Queen has just given permission for the publication of the anatomical drawings and works of Leonardo da Vinci, (born 1452, died 1519). They are among the choicest treasures in the Royal Library at Windsor Castle. Dr. William Hunter, who saw them in the last century, says of them: "When I consider what pains he has taken upon every part of the body, the superiority of his universal genius, his particular excellence in mechanics and hydraulics, and the attention with which such a man would examine and see objects which he was to draw, I am fully persuaded that Leonardo was the best anatomist, at that time, in the world."

The drawings and writings are to be published in *fac simile*, and will consist of about 250 plates, in folio, with the text of MS printed in full, an English and a French translation, and all needful notes and elucidations.

OBSTETRICS, DISEASES OF WOMEN, MATERIA MEDICA, AND THERAPEUTICS.

By THEOPHILUS PARVIN, M. D., Professor of Materia Medica and Therapeutics, Medical College of Ohio, and Clinical Lecturer on Diseases of Women at St. John's Hospital.

ART. I.—*Obstructed Labor—Description of a Case in a Lecture to his Class.* By M. B. WRIGHT, M. D., Prof. Obstetrics and Diseases of Women and Children in Medical College, Ohio.

[Reported by C. O. WRIGHT, M. D.]

GENTLEMEN:—Before I proceed to a consideration of the subject more immediately before us, allow me to give you the outline of a case which occurred last evening and terminated this morning. It is one of obstructed labor from the presence of a fibrous tumor in the cavity of the pelvis, and will illustrate, to some extent, the correctness of views very recently presented.

It would not be doing justice to your memories, after the earnest attention bestowed upon my lecture, to suppose that you are now ignorant of the character and location of pelvic tumors, yet, I am tempted to refresh your minds on the subject.

Tumors of the labia, although not strictly pelvic, have been described as an obstacle to the ready escape of the fœtus. During the course of my practice, I have found the labia enlarged, in several instances, by morbid growths, but never of sufficient size to impede labor. Simple cysts are not unfrequently found on the sides of the pelvis, in the recto-vaginal septum, and recto-vaginal pouch, but they have been mostly of smallsize, compressible and not interfering essentially with the progress of labor.

Ovarian cysts not only attain an enormous size in the cavity of the abdomen, but they have occasionally descended into the cavity of the pelvis, and have attained such size as to encroach seriously upon surrounding organs. Their contents are the same whether in the abdomen or pelvis, varying in consistence from serous, gelatinous, oleaginous to fatty, and while under compression, especially if the walls be thick and firm, may not be readily distinguished from the more solid structures.

The ovaries, in an enlarged state, may fall behind the broad ligaments into the cavity of the pelvis, and occasion the necessity for artificial

delivery. Only a few days ago, I related to you a case, unattended, however, by pregnancy, illustrating the descent, growth, firmness and relations of these enlarged bodies, and not less important, the treatment. It was situated on the left side of the pelvis, and to the touch, was so firm and immovable, as to excite a suspicion that it was attached to the bony structures. The uterus was pushed to the right of the median line, and seemed to be inseparably attached to the enlarged mass. After a few weeks of treatment, mainly by the use of iodine through the vaginal speculum, it had become so far reduced in size as to be movable, and to enable the uterus to resume its natural position. Again, with a slight tap or more continuous pressure against the under surface, it could be elevated above the brim, and finally it could barely be felt.

Steatomatous and fibrous tumors, not to say osseous, may be found attached to the bones, periosteum, or loose tissues.

When polypoid tumors sprout from the neck of the uterus, near the os uteri, their growth is rapidly increased during the progress of gestation. I have already given you a description of one which encircled the os, and gradually extended downward, like a loose vagina within the vagina, growing thicker and thicker, until it became consolidated, increasing also in breadth, until at the end of six and a half months, it had well filled the cavity of the pelvis, the base presenting at the vulva.

The serious aspect of the case, especially in anticipation of the near approach of labor, suggested its removal. A ligature was tightly drawn around the upper portion of the tumor, as high as it could be reached, and in three or four days the greater portion of the mass was removed by the knife. Two or three weeks subsequently, premature action of the uterus commenced, and the ovum was expelled. One year from that time I sought an opportunity to examine the patient, and not a trace of the morbid growth could be detected.

It is generally admitted that soft, compressible swellings of small size, whether distinct tumors or otherwise, may not arrest much, if at all, the healthy action of labor. And I have had no reason to express to you a different opinion. Indeed, the case which occurred at the Commercial Hospital, under the immediate care of a member of the class, might be again presented in support of the principle of non-interference. After an examination of that case, my advice was, "engage in no extra manipulation, and fear no hindrance from the polypus." The advice was followed, and the result was satisfactory.

The polypus, at its upper extremity, measured about half an inch in width, and somewhat less in thickness, gradually assuming a pyriform

shape, until its base reached the vulva, and measured an inch and a half. How much this tumor owed its existence and growth to pregnancy, it is difficult to say, but, soon after the cessation of the lochia it had disappeared.

For the successful management of pelvic tumors during labor, obstetrical writers have given us several directions, viz: allow them to remain undisturbed; remove them by ligature or knife; raise them above the brim of the pelvis and presenting portion of the fœtus; place them in front of the nearest sacro-iliac symphisis.

No delay from the presence of a foreign body was anticipated in the case now under consideration, until Dr. Rosenfeld, the regular attendant, had been called soon after the commencement of labor. A digital examination revealed the presence of a foreign body at the vulva, and completely closing the outlet of the vagina. At first the doctor supposed it to be a detached and partially protruding placenta, with the fœtal surface in advance. The absence of hæmorrhage, and of an umbilical cord, however, led to a more careful examination and a more correct diagnosis.

The presence of so large a foreign body in the pelvic cavity, naturally suggested the necessity of interference and manual delivery. That no unnecessary delay should occur, in deciding upon the proper course to be adopted, I was requested to visit the patient in consultation.

No difficulty was experienced in placing the morbid mass within the cavity of the pelvis, and but little, comparatively, in passing my hand in front of it to the superior strait. The os uteri was found fully dilated, and its entire circle in a normal condition, except that portion to which the polypus was attached. Even this was not unusually vascular nor thickened. As expulsive efforts had not commenced, and were seemingly in a state of suspense, the following questions were presented for our deliberate consideration:

1st. With an ordinary amount of uterine force, may not labor terminate spontaneously and safely?

2d. If artificial delivery should become necessary, shall it be by podalic version or the use of the forceps?

3d. Shall the polypus be removed before any further advance of the labor, or,

4th. Shall it remain undisturbed, except by the progress of labor and accessory pressure?

As the bulk of the tumor was already protruding from the vulva, with an inclination to descend still further, an affirmative answer was given to the first question. From this time—after midnight—until

nine o'clock in the morning, uterine action continued feeble, without any descent of the head through the superior strait. The patient was becoming fearful, restless, and importunate, and it was evident that we would not be justified in confiding longer to the efforts of nature.

This added to the importance of a correct course in answer to the second question. It was feared that in delivery by podalic version, the head might be arrested in the cavity of the pelvis in such a way as to disturb the natural flexion of the fœtal head, and thus bring its long diameter in correspondence with one of the pelvic diameters instead of axes. I have often shown you by the manikin how important it was, in all your maneuvers for artificial delivery, to preserve certain relations between the line from the occiput to the chin of the fœtus and the central curved line of the pelvis. Such relations could scarcely continue with a large tumor in advance of the chin or forehead, and the delivery of the head would be rendered exceedingly difficult, if not impossible, without mutilation.

An answer to the third question, as well as the second, necessarily embraced one of the fourth. The practicability of delivery by forceps was strengthened by the mobility of the polypus and its tendency to descend. It was believed that the forceps could be more readily introduced than the hand and arm, and that by the instrument stronger and better directed traction could be secured.

Forceps were accordingly used, the head still occupying the brim of the pelvis, and labor terminated in a few minutes. Before the occiput escaped from under the arch of the pubis, the larger portion of the tumor had passed over the edge of the perineum. No more compression or traction of the head was necessary than in ordinary cases of inefficient uterine action requiring the use of forceps.

Soon after the delivery of the placenta, a ligature was applied tightly around the neck of the tumor about an inch and a half from its origin, while all below was removed by excision.

The tumor has been brought here for your inspection. It is, as you perceive, of dense fibrous structure, six inches in length and ten inches in circumference.

You will not take this case as illustrating the true and exclusive practice to be adopted when labor is complicated by the presence of a tumor in the cavity of the pelvis. If you should be called to the management of such a case, before having acquired some facility in the art of turning or in the use of forceps, my advice would be, remove the tumor before or soon after the beginning of labor. The obstruction being no longer in the way, the labor would differ in no essential par-

ticular from one of every-day healthful uterine action, or could be terminated by such manual aid as circumstances might seem to demand.

Since the above was written, an interesting letter has been received by Dr. Rosenfeld from Dr. Brandies, of Louisville, who was the medical attendant of the above patient for many years. We have been permitted to extract in substance such parts as may have a bearing on the origin, growth, and treatment of the tumor while the patient was in his hands.

During the progress of an abortion, about two years subsequent to a difficult instrumental delivery, a small tumor was discovered on the edge of the os uteri. Two months thereafter it was surrounded by a firm ligature, and in a few days all traces of disease were effaced. More than a year afterward the morbid growth was again felt, the patient in the meantime having given birth to twins. It was now cauterized until its destruction was supposed to be complete. Three years from this time, following in about a month a natural labor, the tumor again appeared and was treated by the frequent application of nitro-oxyd mercury. This proving ineffectual, the hot iron was again used as at first, and with like success.

More than five years have elapsed since the patient passed from under the careful observation of Dr. Brandies, and nearly ten years since the tumor was first detected. At what time the tumor commenced its last reappearance it is difficult to say, but it was not known to exist up to the time of the labor just concluded.

If the suspicion and reasoning of Dr. Branditz be well founded—that the tumors were vascular, rather than regular polypi—present cure is not certain.

ART. II.—*On Flooding after Delivery, and its Scientific Treatment, with a Special Chapter on the Preventive Treatment.* By LUMLEY EARLE, M.D., Obstetric Surgeon to the Queen's Hospital, Birmingham, etc., etc. London, 1865.

WE like the title of Dr. Earle's little volume—*Flooding*—the simple Saxon is better than the classic Greek, *Hæmorrhage.* It is vivid, suggestive of extreme and instant peril. We like the motto upon the title page, *Nec Temere nec Timide*—neither rashly nor timidly. Rashness and Timidity, these are the Scylla and Charybdis, the perilous passage between which the obstetrician must navigate in the treatment of this most serious complication. Finally, we like the book itself, plain, practical, and in some respects, we believe, original; we wish that every practitioner in the country had a copy. But as

there is neither probability, nor indeed possibility, of the wish being immediately gratified, for the volume has only recently been issued in London, and we know not that any American publisher designs re-publishing it, it seems to us next best to draw from its pages some of its more important lessons, presenting them at some, but not at all times, in the words of the author, conjoining such comments and suggestions as seem to us appropriate. After speaking of the immediate danger arising from a large loss of blood, the author proceeds to say, "flooding renders a woman more liable to severe asthenic diseases, such as uterine phlebitis, phlegmasia dolens, puerperal mania, etc., and when the already weakened frame is attacked by diseases of so grave a character, it is, of course, less able to bear up against the force of the malady."

We have never observed the sequence of any of these diseases upon flooding; but we have known more than one patient to remain many months thereafter in a most wretchedly anæmic condition. And by the way, *puerperal anæmia*, whether thus acute in its origin, or often more gradual—resulting apparently from the exhaustion of vital powers in the development and metrition of a new being, especially observed, too, when the subject of such anæmia has been exposed to marsh-poison—is a disease which has not received that attention in our professional literature its importance demands. Another possible remote consequence of flooding is the development of pulmonary tubercle. It is now many years since an intelligent medical friend, Dr. Gaston, called our attention to the fact that patients bled freely for puerperal convulsions, recovering from them, not unseldom died a few months subsequently of pulmonary consumption. Our own observation since has furnished us with more than one confirmation of this statement. And if true of artificial detraction of blood, at the hand of the practitioner, it will be equally so of that which occurs in flooding. Hence, both in respect to immediate and future danger, it is all-important that the practitioner should readily recognize and promptly and properly treat this occurrence; the life of the patient depends upon such recognition and treatment; delay for counsel will generally be fatal; in the hands of a single one the result rests. But is there no foreshadowing of this great danger and dread of the lying-in room? The older obstetricians taught us that frequency of the pulse betokened the coming peril—"no woman is to be considered safe whose pulse is above a hundred." This rule, valuable as it is, should not be exclusively relied upon either negatively or positively. Dr. Earle, who states his belief to be that whenever a rapid pulse after delivery is connected at all with hæmorrhage, the undue loss of blood is actually going on at the time, very correctly asserts that other causes may produce great frequency of the pulse, and also that in some instances of actual flooding the pulse was not above eighty. Among other signs of flooding may be mentioned hurried breathing, dilated pupil, excessive pallor, dimness of vision, faintness, then fainting, free perspiration, restlessness and tossing, convulsive movements, etc. Of course the practitioner should ascertain at the first intimation of danger, with

eye and hand, the amount of discharge and the condition of the uterus. But what is the preventive treatment?

"Flooding will be most frequent in the practice of those medical men who trust too much to nature, or are, on the contrary, too meddlesome." "The precautions which we may employ to prevent flooding after delivery, should have for their aim, more or less, the insuring of two points—*perfect rest of body* and *perfect contraction of the uterus.*" Dr. Earle then gives some seventeen *precautions.* The first of these is, prompt attendance when summoned to a case of labor; the second is, the patient ought to be confined in bed—not at its foot, not on the floor, nor upon chairs. The third precaution we think of sufficient importance to give almost entire and in the words of the author, differing as it does from the general practice:

"A small table-cloth, or if there are two binders, one of them should be adjusted before the termination of labor; in fact, as soon as the patient is undressed. It ought to be passed (the patient standing up) once round the abdomen outside the skirt, and made to reach a little above the fundus of the uterus and a little below the hips, and then pinned four or five times on the *right side* of the patient. It should not be drawn tight, except where the uterus is very much anteverted from great flaccidity of the abdominal walls, as it would prevent the fundus from taking the natural forward movement during a contraction. I used to put on the binder after delivery, but to adjust it properly while in the recumbent posture, requires a considerable amount of exertion on the part of the mother, as some difficulty is generally found in getting the lower edge well under the hips; and sometimes it gets twisted, then it has to be removed and re-applied. There are many advantages in adjusting the binder before delivery. 1st. Perfect rest of body is insured. 2d. The binder can be more easily and more equally applied. 3d. By pinning it on the right side of the body, as the patient lies on the left, we are enabled to tighten or loosen it at pleasure." Another precaution is to see that the patient evacuate her bladder frequently, as a distended bladder is not an uncommon cause of post-partum hæmorrhage. Still another is, "when the patient lies down, care ought to be taken that the head and trunk are placed higher than the pelvis, especially just before the birth of the child; otherwise hæmorrhage is liable to be set up by the blood gravitating to the upper part of the vagina, and there forming a clot, instead of passing away out of the vulva. The vaginal clot obstructs the escape of the blood from the uterus, and affords time for coagulation in the cavity of that organ. Clots in the uterus are a most common cause of post-partum hæmorrhage."

An important rule to be observed in the case of a patient who has flooded in previous labors, is to give a dose of ergot as soon as the head is born, and another as soon as the birth of the child is completed. So, too, in case of uterine inertia, the pains at long intervals and the labor very slow, we may be pretty sure such inertia will persist after delivery, and ergot should therefore be administered. The eighth and ninth rules are to have the nurse, when the head is born, place her hand upon the fundus of the uterus, and to follow the uterus down as she feels it descend during the expulsion of the

infant; and to let the expulsion be effected solely by the efforts of nature, unless the infant's life is in danger. These are directions which, though important, are familiar to all practitioners. But the ninth precaution is one which is not so generally recognized, it has reference to the influence of cough in inducing hæmorrhage, and the direction is given to quiet it, when it occurs during labor by an opiate.* We believe that every practitioner of experience will be struck with the wisdom of this suggestion. After the delivery of the child, the binder should be tightened if the uterus is well contracted; but if it be large and flabby, it should be left unfastened, and the practitioner should resort to *gentle* and *equal* pressure, with the hand upon the uterus, which is as useful in preventing hæmorrhage as *strong pressure* is in the treatment of it. On the other hand, great compression and "kneading" at this stage are very apt to induce irregular contraction of the uterus, or partial detachment of the placenta, and thence flooding. The eleventh precaution relates to the delivery of the placenta, justly spoken of by the author as "the most important and anxious part of natural labor." "Women regard that accoucheur the most skillful who brings the child into the world the most quickly; whereas, if they knew better they would judge his skill rather by the way he managed the delivery of the placenta than that of the child." The placenta should be removed as soon as detached. Ordinarily the evidences of such detachment are, readily feeling with the finger the insertion of the cord and a considerable portion of the placenta, and the flaccidity of the cord; this removal, of course, should occur during uterine contractions, the placenta should be expelled too, rather than drawn from the vulva. The twelfth precaution directs a thorough examination of the placenta and membranes, to see whether they have come away perfect. We are satisfied that this is often, we had almost said *generally*, neglected. The late Dr. Charles Parry, of Indianapolis, one of the best practitioners we have ever known, years ago narrated to us three cases seen by him in consultation, of most alarming and well nigh fatal hæmorrhage, occurring respectively one, three and five weeks after delivery—hæmorrhage which had baffled all treatment, until he in each case fortunately succeeded in removing a fragment of placenta, much to the astonishment of the medical attendant! Life was saved in these instances, but are there not many where it has been sacrificed from the neglect of the obstetrician carefully to examine with both eye and finger the placenta immediately upon its expulsion? "If a large portion of the placenta is found missing, or the membranes *are known* to be left behind, an attempt should be made to remove them at once, rather than allow the patient to run the risks of flooding and puerperal fever." Precaution thirteen is as follows: "Place the left hand next to the skin over the uterus, and while it is pressing the fundus down, pass the index finger of the right hand into the vagina, and remove any clots of blood obstructing the os uteri. In removing the finger, I generally press the posterior wall of the vagina, at the same time pressing the uterus outside, and telling the patient

* Bottley's solution is the form advised.

to bear down. By these means, if there should happen to be a clot *in utero*, it very often slips out. It is very important to remove any clots obstructing the os uteri, for a clot in that situation is in many cases a primary cause of post-partum hæmorrhage."

Dr. Earle advises a pad, made by folding two or three napkins, to be placed partly over and partly above the fundus of the uterus, the binder fixing it in place. When there has been flooding, a safer pad—this seems to us an excellent plan—consists of three big napkins rolled up separately; one should be placed transversely above the fundus, the other two perpendicularly, one at each side of the uterus The upper extremities of the side pads should lie over those of the upper pad. In this way the uterus becomes enclosed, as it were, in a box; the bandage fastened tightly over these pads, distension of the uterus is almost utterly impossible. He advises, when the uterus does not contract well, compression of the mammary gland. "If we place one hand upon the uterus, while we grasp the breast with the other, the uterus will be felt to contract instantaneously." Very properly, he advises this effort to excite the sympathy between the breast and the uterus, to be made by the nurse rather than the physician; and instead of squeezing the breast, she may simply imitate with her thumb and finger on either side of the nipple, the compression and traction of an infant in sucking.

Finally, and with these precautions completing the *Preventive Treatment of Flooding*, given by our author, we must dismiss the subject for the present—it is better not to disturb the patient for an hour after delivery; then, provided there is no hæmorrhage, let her soiled clothes be removed; nor should the practitioner leave the house until the period; the excellent injunction of Dr. Arthur Farre is quoted: "If you stay with your patients for an hour after their delivery, you will very rarely be called back again; if you don't, you may lose a patient from flooding."

We hardly believe an apology is necessary for the fullness with which we have entered into this partial review.

It is true some truths old and familiar to many of our readers have been brought forward, yet likewise some that are new, and junior practitioners, we are sure, will be grateful, both for old and new, for to have presented to his consideration a condensed view of the best means of preventing hæmorrhage after parturition, will lighten the load of anxiety which oppresses every young obstetrician in the lying-in room.

PRACTICAL MEDICINE, PHYSIOLOGY AND CHEMISTRY.

By ROBERTS BARTHOLOW, M.D., Professor of Physics and Medical Chemistry in the Medical College of Ohio; Lecturer on Clinical Medicine and Physician to St. John's Hospital, etc.

ART. I.—*The Progressive Locomotor Ataxia (ataxie locomotrice progressive).* By ROBERTS BARTHOLOW, M.D.

A case of this comparatively rare form of nervous disease has been for some time under my charge in St. John's Hospital. The attention which has been attracted to it for some years, and the importance of the subject itself, seem to justify me in making this case the text for some observations upon the history, symptomatology, pathology and treatment of this affection.*

Stewart Kelch, by occupation a gilder, was admitted to St. John's Hospital, service of Prof. Bartholow, Feb. 10, 1866.

He gave the following history:

About the 15th of December last he began to experience some troubles of vision; objects were confused and indistinct; soon after he had double vision. He noticed that his food had no taste about the same time. His hearing and smell were unaffected. In consequence of these ocular troubles he consulted a female doctor who had some reputation as an oculist, who prescribed an eye-wash and some medicine. Finding that no improvement took place he consulted a well-known oculist in this city, who, after a prolonged ophthalmoscopic examination, directed glasses and gave him some internal remedy. His eyesight, soon after this, suddenly improved.

Whilst he was in attendance upon the female doctor, he began to experience numbness and lack of voluntary control in the inferior extremities, and the apparent loss of power and the difficulty of locomotion were well marked during the period he was under the care of the oculist, who, probably, did not recognize the nature of the malady.

Soon after troubles of the same character appeared in the upper extremities.

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* I have made liberal use of the prize essay by Dr. Paul Topinard, *De L'Ataxie Locomotrice, et en particulier De la Maladie appelee Ataxie Locomotrice Progressive. Paris*, 1864.

During the whole period he suffered from nocturnal emissions, satyriasis and at length complete impotence. He had had some troubles in micturition and defecation, the desire coming on suddenly and the evacuation occurring immediately.

He had no rheumatic pains. Pricking and tingling in the extremities and a dull pain in the loins and limbs, which appeared about the time his ocular troubles began, were the only symptoms of this kind.

Symptoms on admission.—Kelch is 36 years old, 5 *ft.* 6 *in.* high, light complexion, lymphatic temperament, full face with prominent lower jaw; very protuberant blue eyes.

He has no troubles of vision at present except some dimness of sight; his eyes are more prominent than natural. His face is expressionless. His taste has returned, but his tongue is protruded to the right. Sensibility, both tactile and muscular, diminished in the upper extremities, especially the right. Power of co-ordinating movements not completely lost, but diminished, in consequence of which his attempt to grasp any object is uncertain and vacillating. He can not use his knife and fork. He complains especially of a sensation of numbness in his hands and forearms, and a sense of pricking. They are, .5° F., colder than natural. There is no wasting of the muscles, but a contraction of the central tendon of the *extensor communis digitorum*. His grasp is as strong nearly as in health.

When requested to stand with his feet together and his eyes closed. he can not do so without the support of a chair. He walks as an unpractised youth on stilts. When requested to walk across the room, he rather runs than walks, and evidently can not control the movements of his feet, which are thrown up and down and laterally, in the most irregular manner. The chief sensation in his feet is that of numbness. Tactile sensibility and myotility are more diminished in lower than upper extremities. He perceives the galvanic shock when a strong current is passed through his limb, but feebly. The muscular sense is almost abolished. In walking, he can scarcely feel the floor, and when his eyes are not fixed upon his feet, he can not direct his movements.

He has been for some weeks entirely impotent.

His intellect appears to be unimpaired.

Treatment.—He was put upon the crystallized nitrate of silver, 1-6 of a grain *ter in die*. After ten days' use of this remedy, I gave him 30 grains of the iodide of potassium daily. His improvement under this treatment has been most marked. He is very rapidly regaining the power of co-ordination of muscular movements, his cutaneous and muscular sensibility are returning; he walks with considerable vigor

and certainty, and he begins to experience sexual desire with erections. The iodide of potassium seemed to be indicated by the fact that the patient had for ten years followed the profession of a gilder, and had during that period of time, absorbed more or less of the mineral matter used in the prosecution of his trade. As M. Melsens has demonstrated that this remedy makes soluble combinations with these mineral poisons, thereby facilitating their excretion, it was applicable to the treatment of this case on the theory that the alteration in the spinal cord might be due to the slow and long continued action of the minerals. Moreover, the iodide of potassium is one of the most reputable remedies in this affection.*

HISTORY. The name, *ataxie locomotrice progressive*, was given this malady by Duchenne of Boulogne, who described it with more particularity than any of his predecessors, but he is not entitled to the merit of discovery. It had been recognized in England in 1847, and was well described in Germany in 1834, but under other names, as paraplegia with disordered co-ordination of movement, *tabes dorsalis*, gray degeneration of the posterior columns of the spinal cord, progressive spinal paralysis, etc.

The most ancient of these terms, *tabes dorsalis*, originated with Hippocrates, who applied it to the accidents produced by the abuses of venery. The passage in which the term occurs is found in *De Morbis*, usually ascribed to Hippocrates, but by Dr. Adams, translator of the the Sydenham Society edition of the works of Hippocrates, is assigned to the Cnidian school: *Tabes dorsalis a spinali medulla oritur, maxime vero recentes sponsos et libidinosos corripit.*

Sauvages, a long time after, described a group of symptoms, produced by the same cause, which closely correspond to the disease now known as progressive locomotor ataxia. Lallemand also, under the title of the "dorsal consumption," described a set of symptoms of the same character.†

The term *tabes dorsalis* was, by the Germans, changed in its signification, and applied to a disease of the cord characterized by atrophy of this organ. The first autopsy, clearly establishing this condition of the cord, was made so long ago as 1679. The disease was very clearly described in Hufeland's Practice of Medicine, under the name tabes dorsalis, in 1834. Steinthal, in 1844, was equally explicit in his details concerning this disease, describing, as had Hufeland, the difficulties of

* See reports of two cases in the *Medical Times and Gazette*, treated with this remedy, Jan. 27, 1866. They were only improved, however.

† *Des pertes seminales involontaires. Paris et Montpelier*, 1839–41.

locomotion, the loss of power of co-ordinating muscular movements. the amaurotic amblyopia, etc.

Romberg,* in 1851, under the same name of tabes dorsalis, and Wunderlich, the following year, under the title of progressive spinal paralysis, particularize with great precision the essential phenomena of this disorder.

The morbid anatomy of progressive locomotor ataxia had been studied with the naked eye only, prior to 1857, in which year Ludwig Turck published a memoir at Vienna, in which he described the microscopic appearances of the degenerated posterior columns of the spinal cord. Virchow and Raciborski confirmed these observations, which had established that the alteration proper to *tabes*, consisted in an atrophy of the nervous elements with hypertrophy of the intermediate connective tissue.

Whilst these observations were accumulating in Germany as to the nature of tabes dorsalis, attention was being called in England to defects of co-ordination, dependent upon an affection of the cord. Todd, especially, influenced by the theoretical views which he entertained as to the functions of the posterior columns of the spinal cord, and having had two cases in which defects in the co-ordination of voluntary movements existed with integrity of the muscular force, diagnosticated during life and confirmed by *post mortem* observation, a lesion limited to the posterior columns. "Two sorts of paralysis of movement," says Todd, "are found in the inferior extremities; one consists in feebleness or loss of voluntary movement; the other is distinguished by diminution or complete abolition of the power of co-ordination of movements." He says nothing, however, of ocular troubles.

In 1856 and 1858, Gull published in Guy's Hospital Reports a long series of observations, relative to diseases of the cord. In one case he observed trouble in the co-ordination of movements and alterations of the posterior columns of the cord. Gull, ignoring the labors of the Germans in the same field, and the investigations of Duchenne not having yet seen the light, did not hesitate to ascribe these phenomena to chronic myelitis.

In France various observations were made and recorded in the proceedings of the anatomical society, and in the immortal work of M. Cruveilhier. These observations extend from: 1828, those of M. Hutin; 1830, those of M. Cruveilhier; 1845, those of M. Fredault; 1847, those of Monod; 1856, those of M. Luys; to 1858, those of M. Laborde.

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* Manual of Nervous Diseases. *Syd. Soc. Trans.*

It is subsequent to these observations that M. Duchenne announced in the *Archives de Médicine* of 1858, the existence of a new disease which he proposed to call "*ataxie locomotrice progressive*," describing it in these terms: "Progressive abolition of co-ordination of movements and apparent paralysis, contrasting with integrity of the muscular force." This able observer ignored the ideas of Todd and the labors of Hufeland, Steinthal, Romberg and Ludwig Turck. His merit consists in this: that he comprehended the relation of the symptoms, their habitual succession, and insisted more than Romberg had done, upon the ocular troubles. This was certainly the view of the merit of Duchenne entertained by Trousseau, when he baptized the new disease by the name of its presumed discoverer.

SYMPTOMATOLOGY.—The duration of this malady is from one to thirty years; hence, it is useful to make some divisions to facilitate the description. We adopt the division of M. Duchenne: "The *ataxie locomotrice progressive* is divisible into three periods: the first characterized by three symptoms—pains, ocular troubles and anaphrodisia; the second, by disorders of muscular sensibility and of the sensibility of the inferior extremities; the third, by the extension of the same troubles to the superior extremities."

Pains.—These are in general the first symptoms to attract the attention of the patient.

In one hundred and four observations made with reference to the frequency of the pains and the period of their appearance relative to the ataxic symptoms, they were present in forty-four before the locomotor ataxia; in twenty, after; in eighteen, present, but time not definitely fixed; in twenty-two, absent.

They were present in the case of Kelch after the locomotor ataxia.

These pains are observed in all diseases of the cord, but are more frequent in progressive locomotor ataxia.

At their origin, these pains are fugitive and distributed over the surface of the body or one of its lateral halves, or they are limited to one region, to one extremity, especially to the feet. If, after having been generally distributed, they disappear in the superior half of the body to concentrate in one limb, this part, in which a primitive or secondary localization of the pains has taken place, is destined to be the first attacked by the ataxic disorders. They are sometimes superficial, sometimes deep-seated, in the muscles or in the neighborhood of the large joints. They are encountered in the head, jaws, orbital cavities, external auditory canal, the urethra, the deeper parts of the pelvis. In the globe of the eye they give rise to congestive phenomena, identical with

those that accompany neuralgia of the fifth; injection of the conjunctiva, lachrymation, heat, dilatation of the pupil.

These pains are resolvable into two classes: the one, dull and nearly continuous, exceptional; the other, short and sharp, habitual.

The first have been compared to the sensation produced by the constriction of a limb by a cuirass.

The second, are sharp pains in the extremities shooting toward the trunk; more rarely, they are likened to flashes of fire, puncture of an awl, strokes of a hammer, or vibrations flowing along in the direction of the muscles, or more commonly, as a *tic tac* in some point like that of a watch.

Their fundamental character is their mobility and intermittence. They may appear and disappear many times a day, and the attacks vary in duration from some hours to seven days or more. It is exceptional for them to increase at night. Sometimes the pains are so horrible as to justify the expression of Remak: *tabes dolorosa.*

Their analogy with certain rheumatismal pains is remarkable. They are influenced by all those atmospheric causes which exasperate rheumatic pains. Hence it is that winter is a bad season for the ataxic.

Functional troubles of the cranial nerves.—These functional derangements of the cranial nerves were well marked in our case. He had amblyopia, diplopia, protrusion of the eye, paralysis of taste, etc. The comparative frequency of these functional troubles of the cranial nerves—optic, motor oculi, hypoglossal, auditory, facial, glosso-pharyngeal, etc., without regard to period is as follows: present in ninety-seven cases; absent in twenty-eight.

The cranial nerves are divisible into two or three orders: the first preside over movement; the other over special sensibility, but some of their filaments have general sensibility. What is the nature of the disorder proper to each?

It is evident that the alterations of the optic, auditory, lingual, trigeminal (sensitive part), produce but two orders of phenomena: hyperæsthesia (the neuralgic or rheumatic pains already alluded to); special anæsthesia (amblyopia, paralysis of taste).

In regard to the motor oculi, facial, inferior maxillary, hypoglossal, that portion of the pharyngeal plexus which presides over the muscular sensibility of the vail of the palate, and of the pharynx, and the recurrents, their functions will be exalted, or abolished, or perverted; the muscles to which they are distributed will be either paralyzed or ataxic.

The phenomena proper to the motor oculi are constantly paralysis, except two cases in which Friedreich saw double bilateral nystagmus, and one in which M. Beau speaks of defects in the co-ordination of the movements of the eyes.

Facial hemiplegia, when there exists greater or less irregularity in the two sides of the face, has been noticed.

Embarrassment of speech and pronunciation has been observed in sixty-seven cases.

The time when these functional troubles of the cranial nerves appear varies. The ocular troubles in more than half of the cases appear in the first period, a little after the pains and sometimes in their absence; the feebleness of vision and the embarrassment of speech appertain to the second period; and the dysphagia and the paralysis of the vail of the palate to a still more advanced period. The most ephemeral and intermittent of the ocular troubles are the diplopia and strabismus. The temporary character and spontaneous disappearance of these accidents give rise to a therapeutic illusion. Thus, the subject is surprised by them in good health; the pains which precede or accompany them are referred to rheumatism; the connection between the two is not understood. He goes to an oculist who diagnoses congestion of the papilla or paralysis of the third pair, orders an unguent and collyria, electrizes the orbital cavities, and as if by enchantment the malady disappears. These examples are very common. It is the history of our own case. Did the oculist effect a cure? The symptoms would have disappeared as well with cold water.

The disorders pertaining to the orbital cavities are paralysis of motor oculi, producing ptosis, external strabismus, diplopia, and dilatation of the pupil; paralysis of the motor externus, producing internal stabismus and diplopia; paralysis of the patheticus, producing also diplopia and strabismus and other vague symptoms. Finally, kopiopia, amblyopia, and amaurosis occur. The diplopia is generally attributed to defect in the convergence of the two visual axes upon the object examined.

The condition of the retina, according to the ophthalmoscopic examinations, consists in congestion or atrophy, more or less advanced, of the optic papilla. This is confirmed by some post-mortem observations; in others, however, no alteration is found after death. The absence of lesions, remarked by various authors, in the cranial nerves affected with functional troubles, is in conformity with the temporary character of the different symptoms. It is this fugitiveness which

enables the distinction to be made between them and similar maladies arising from other causes.

Troubles in the genital organs.—In respect to importance, the disorders of the genital organs take place after the pains and ocular derangements. In Germany especially, where the ancient views on the subject of *tabes dorsalis* are not yet forgotten, a particular interest attaches to these symptoms. That venereal excesses are causative can hardly be admitted. As it is difficult to question females, all our observations are silent with regard to them. Moreover, nocturnal pollutions may occur without constituting a morbid state. Finally, the subjects who are attacked by this malady have generally attained the age of from thirty-five to forty years, the period of natural decline in the sexual desire.

Four symptoms present themselves: spermatorrhœa, anaphrodisia, and impotence. The first occurs among the earliest symptoms of the first period. In the case of Kelch, spermatorrhœa had existed for six months prior to the occurrence of the ocular troubles. He admitted to venereal excesses. The nocturnal pollutions, accompanied at first by erection and pleasurable sensations, finally became passive. After the spermatorrhœa, or sometimes preceding it, there is a progressive diminution of the venereal desires, difficulty in satisfying them, and at length complete impotence.

Vesical disorders are observed in some cases. The trouble consists in slow emission of the urine, incompleteness in emptying the bladder, and inability to determine when the emission of urine has terminated. Incontinence has been observed, but retention rarely.

Among the disorders of micturition is found anæsthesia of the vesical and urethral mucous membrane, in consequence of which the individual is unconscious of the emission of urine. The dysuria, as the ocular paralysis, is temporary and intermittent.

Rectal troubles are rare. Constipation is habitual. When the matters are liquid they escape before the patient has time to reach the closet. Incontinence does not occur until about the commencement of the second period.

These vesical and rectal troubles occurred in our patient Kelch.

(In the next number of the Journal we will resume the consideration of this subject, commencing with the second period.)

ART. II.—*Observations on the Asiatic Cholera, as it appeared in Cincinnati in* 1849–50. By THOS. CARROLL, M.D. (Read before the Academy of Medicine.)

(We are indebted to Dr. Carroll for a copy of his paper. Its great length precludes the publication of the whole of it; but we make a full abstract, to put our readers in possession of Dr. Carroll's valuable facts and the conclusions to which he arrived.)

Cholera reached New Orleans in the ship *Swanton*, Nov. 11, 1848. The first cases occurred in Cincinnati as early as the 21st of December. The decks of many steamboats on the waters of the Mississippi became charnel houses at an early period. From January 1, 1849, until the close of the cholera season in September, but few days elapsed without the occurrence of cases in Cincinnati. On the 10th of May, Judge Brough suddenly died of cholera. His death, combined with his position in society, had the effect to produce general alarm and consternation among the citizens of both town and country. By the 15th of May the pestilence had gained a firm footing. From the 16th of June to the 16th of July, 2475 died of cholera, according to the Board of Health, but this in Dr. Carroll's opinion, did not represent the actual number by many hundreds.

By the 1st of July, we had, by constant observation and inquiry, ascertained that the pestilence had reached every part of the city; but on the 20th, the fatality had diminished to 32 deaths, and on the 30th but 9 fatal cases were reported. Dysentery, small-pox and varioloid prevailed after the decline of cholera.

The cholera of 1850, differed from the epidemic of the preceding year both as to the time of appearance and disappearance, as well as to mortality and severity of symptoms. In this year it did not appear till the last week in June, and had run its course, in a great measure, by the end of July, disappearing, except in a few instances, before the middle of August. Not quite 900 cases were reported to have died of the pestilence, although the reports of the Board of Health were more accurate than in the preceding year.

Causes.—Filth, overcrowding and neglect of ventilation, were very influential, of which there are some instructive examples given.

In one house in the north-eastern part of the city, 28 fatal cases occurred, 16 of them succumbing in a single night. The action of these causes was exhibited in the mortality along the White Water canal, which traverses a part of the lower terrace on which the city stands, and about Deer creek to the border of the second terrace. It is remarkable, that in the whole distance from the mouth of Mill creek to Fulton—a distance of nearly three miles—there were in the houses opening immediately on the river, very few deaths, and nearly all those that did occur, were among those who were landed from boats, laboring under the disease. Yet a considerable portion of this space, including the public landing from Vine street to Deer creek, is occupied by

drinking shops of the lowest character, and witnesses more dissipation, probably, than any other quarter of the city. This remarkable exemption can only be explained by the fact that the whole line of buildings in question enjoys constant currents of fresh air from the river.

The rivulet which bears the name of Deer creek emerges from a gorge in the hills in the north-east and constitutes the extreme eastern boundary of the second or upper terrace of the city. The very narrow valley through which the stream runs, is constantly filled with an incalculable amount of filth. Slaughter houses abound here, and during the great swine-killing season the rivulet is constantly dyed with blood. It is said that no cases occurred in this valley in 1832. In 1849, however, not only did the inhabitants of the valley suffer severely, but the malady extended to the very summit of Mount Adams.

In the more central and refined part of the city the mortality was much less. On Fourth street, for example, which is more than a mile long, there were in 1849 not more than 14 deaths. On Seventh, Eighth and Ninth streets, where the population is of a mixed character, there was the same exemption from the epidemic. This is a favored section as regards space, ventilation, cleanliness of the houses and streets and the personal condition of the people. Near the market-house on Fifth street, are some exceptions to the foregoing. In one house two and a half stories high, there resided a number of families, making in all about one hundred inmates. On the 1st of June, 1849, the two upper stories, alone, contained nearly seventy persons, and of these 24 died within three months. It is worthy of notice that in the first story, although considerably crowded, not a single death occurred. The persons occupying this floor were, however, entirely disconnected from those above; were, I believe, most of them of a different religious faith and more cleanly in their habits.

That part of the upper terrace lying between the base of the hills on the north and Fulton street on the south was severely visited. Much of the population of this district is German, and in many places it is densely crowded. In Abigail street, which extends through two squares only and is narrow and crowded, there were 80 fatal cases in 1849.

A marked exemption from cholera was found in the Society of Friends, as there was not in that body during the whole of '49 a single fatal case, and but a single one in 1850. It is well known that the members of this society nearly altogether avoid crowded assemblies, go to meeting but once on Sunday, stay but a short time, never give way to much excitement, and that their meetings for worship are comparatively small, except on rare occasions. At home they live in a simple but most healthful way; every portion of their dwellings bears the impress of cleanliness and all their habits are regular compared to that of the world in general.

Meteorological conditions, according to Dr. Carroll, had no ascertained relation to the prevalence of or exemption from cholera. Now, if we review the ground we have gone over, it will be seen that the pestilence walked abroad without paying much attention to the condition of the weather or the

water; and that, although the other circumstances we have named, such as filthy habits, ill-ventilation, exposure to the hot sun and intemperance, are undoubtedly to be considered in the light of auxiliary causes, yet, as there was nothing in these peculiar to the year of its greatest fatality, it is evident that we must look in some other direction for the primary cause of its origin and propagation.

Various theories have been invented to evade the necessity of adopting the belief that cholera is contagious; but the opponents of this view have, as it seems to us, signally failed to assign any other plausible explanation of its dissemination. The question of contagion is one of such importance that we shall be excused for stating at some length such facts as go to confirm the opinion above expressed. We shall not confine ourself to the city of Cincinnati, for a crowded city is not, we think, the place to find decisive arguments in favor of the contagious nature of any disease. We must resort to isolated communities, or to those having little connection with the population of cities. Such a community, or family, may be visited by an individual, coming from a locality with which they have been heretofore entirely disconnected, who falls sick among his new friends, is taken care of by them, and is discovered in due time to have, if you please, smallpox. Subsequently the family who have nursed him are attacked in the same manner; the friends and neighbors who visit them suffer in the same way, and in time, *their* neighbors and friends. Evidence of this kind would seem to place beyond doubt the contagious nature of any disease; and facts quite as striking as those just supposed, can be quoted to show that cholera is so. Of these a few instances will be given.

A stranger from Pittsburg arrived in this city and spent the night here. On the following day, or within a day or two, he left the city, and arrived at nightfall at the house of a relative, some thirty miles distant. During the night he became ill of cholera, and, within a short period died. The family consisted of nine persons, of whom, within three days after the death of their visitor, all, excepting one old lady had died of cholera.

A farmer came to this city on business early in May, 1849, and returned home the next day. On the ensuing day he became ill of cholera and died. Within two or three days more, his wife and four children were all dead.

A farmer by the name of Smith, who resided some ten miles from Cincinnati in a healthy locality, came to town on business, went home the same day with a slight diarrhœa; during the night ensuing became worse, and in thirty-six hours died. In two days more, two other members of the family became ill and soon died. Within a week from this time there were three more fatal cases. But two of the family were left.

Dr. Carroll adduces numerous striking facts of the same character, but we have not space to insert them. The remainder of this valuable paper is occupied with a discussion of the symptomatology and treatment of cholera.

ART. III.—*The Physiology of Man; Designed to represent the existing state of Physiological Science, as applied to the functions of the Human Body* By AUSTIN FLINT, Jr., M.D., Professor of Physiology and Microscopy in the Bellevue Hospital Medical College, New York, etc., etc. New York, D. Appleton & Co., 1866., p. 502.

It is a hopeful indication of the future of our indigenous medical literature, that American writers will prepare and American publishers print, so elaborate volumes as this. Heretofore, as a general rule, our medical writers have been content to prepare manuals and text-books, and have scarcely ventured into the higher walks of medical literature. It must be admitted that many of these manuals and text-books are models of their kind, in respect to correctness, completeness and originality. It is a just reproach that we have depended too much on our trans-atlantic brethren, especially our English brethren, who with true John Bull impertinence, have depreciated us for our modesty.

In Physiology we have been well represented by Dalton, whose work as a manual or text-book leaves nothing to be desired. Prof. Flint proposes to himself a much more elaborate treatment of the subject than the size of Dalton's volume would permit. The present is the first part of a treatise on the physiology of man, which is to be issued in three parts, one each year until completed, "each, however, forming a distinct treatise, devoted to natural subdivisions of the subject. The volume now issued embraces an Introduction, the Blood, Circulation and Respiration."

The introduction is devoted to a discussion of Proximate Principles, in which he follows the classification of Robin and Verdeil—authors of whose labors he has made liberal use throughout this volume. He divides them into two classes:

FIRST. *Substances which enter into the normal constitution of organized tissues, and those constituents of the fluids which are used in nutrition.*

SECOND. *Substances which are the result of the wearing out of the tissues, and are not used in nutrition.*

These are all discussed very briefly but comprehensively, in accordance with the design expressed in the preface, to embrace physiological chemistry only so far as necessary "to elucidate the functions of the organism." We observe a defect of arrangement in treating of the composition and properties of organic principles. An account of Proteine is interpolated between putrefaction and catalysis.

The chapter on the Blood contains a very full and satisfactory discussion of the subject. He coincides in view with Dalton, that blood corpuscles are 'independent anatomical elements," or as our author expresses it "true anatomical elements." He makes some excellent observations on the methods of analyzing the blood, and as is natural gives preference to his own, which is intended to estimate the organic principles with their water of composition, and "united with the inorganic salts, which can not be separated from them without incineration and consequent destruction."

Dr. Flint is an advocate of the ammonia theory of Dr. Richardson in explanation of the coagulation of the blood.

The chapters on the circulation are also very complete and satisfactory. An account of this subject is preceded by an historical outline of the various stages of discovery. He alludes in a foot note only, to the discussion of Kellie's view, that the quantity of blood in the brain is invariable, and agrees with Burrows' conclusions that great variations may exist. He does not allude to Bennett's review of this controversy and his conclusions in support of Kellie's position.

The chapters on respiration are excellent. Our space will not admit of an analysis of them. This is the less necessary, however, as the notice we have given, sufficiently exhibits the design and character of the volume.

We are pleased to observe that the author has had the good taste to omit the stereotyped cuts which are perpetuated in physiological works.

The work is admirably printed on tinted paper, and is a most agreeable book to read.

We congratulate Prof. Flint upon his very successful essay as an author We trust that the work will receive the attention its merit deserves, to encourage the author in his efforts to give us an elaborate treatise on Human Physiology, and to convince the publishers that American physicians appreciate the labor of their own countrymen.

The Trichina Disease.

Severe epidemics of *Trichinosis* have lately occurred in Germany. Very interesting accounts of the outbreak at Hedersleben, in Prussian Saxony, have been published.

A butcher having slaughtered two pigs, most of the consumers, among whom were many factory hands, ate the chopped flesh in a raw condition. The following symptoms were observed in these cases: Vomiting and choleriform diarrhœa, accompanied by peculiar pains of the flexors of the extremities; excessive sweating; sleeplessness; small and quick pulse and great abdominal pain. The diarrhœa sometimes ceased spontaneously, and between the third and fifth week great oppression of the respiration set in, marked by symptoms of intense dyspnœa, occurring chiefly at night; and when autopsies have been made in these cases, abundant migration of the *trichinæ* into the respiratory muscles, and especially the diaphragm was discovered.

The period of incubation might be said to range from two days to four weeks. The favorable condition of childhood is remarkable, for of more than 100 children affected none have died.—*Medical Times and Gazette.*

MISCELLANY.

The Cincinnati Academy of Medicine.

Dr. Thos. Carroll, *Pres't.* Dr. M. B. Graff, *Sec'y.*

Since our last report, the new officers have been inaugurated. Dr. McIlvaine, on retiring from the chair, gave an interesting account of the progress during the last year in membership, fullness of attendance, and in the increased interest of the medical discussions. He proposed that means should be taken to secure a charter for the Academy, to procure a sufficient library, and to obtain more suitable rooms for the meetings.

Dr. Carroll's inaugural was intended to exhibit some of the varying phases of medical opinion during the past thirty years; he enjoined on all, especially the younger members of the profession, the cultivation of the collateral sciences.

The discussion on cholera was resumed by the reading of a paper by Dr. Taliaferro, detailing his extensive personal observations in 1832 and 1849. Dr. White in discussing the therapeutical doctrines announced by Dr. Taliaferro, took occasion to ventilate the therapeutics of "common sense"—a new view, it must be admitted, of the *methodus medendi.* Dr. White opposes the calomel treatment of cholera, which, in his view, is *nonsense* rather than common sense. Dr. Almy, whose method of treatment by calomel we gave in a previous number, defended the use of calomel, opposing to Dr. White's objection the sound *common-sense* doctrine, that the remedy which is successful in the largest number of cases is the best remedy.

Dr. Comegys also took issue with Dr. White on the use of calomel in cholera. He adduced some striking instances of the efficacy of large doses—120 grains in four hours in one case. He argued that calomel is administered not necessarily with a view to its absorption, but for its local effect. He advocated the doctrine that there is an essential unity in the ends proposed by the various methods of treatment, the object to be accomplished being essentially the same.

Dr. McIlvaine took occasion to correct some of the statistical, geographical, and other errors which have been announced in the course of the discussion.

Dr. Bartholow, under the head of reports of cases, presented the case of Kelch, published in our present issue, of Progressive Locomotor Ataxia, with some remarks upon the history, symptomatology, and pathology of that affection.

Medical Experts.

In cases of a complicated nature and involving important interests, it is customary to call in medical or scientific experts, who, by reason of their special experience in certain branches of the profession, are presumed to be able to guide the court to a proper understanding of the facts of the case.

There are many of these cases, including some in criminal law, which could not possibly be settled without this collateral aid—the questions at issue not being based on matters of fact occurring within the ordinary range of practice, so much as on an enlarged experience in a particular department.

"There is, however, a strong public feeling against the admission of experts. One able writer remarks: 'It is impossible to shut out evidence altogether, but there is nothing which brings more discredit upon the administration of justice. There is one consequence of its admission which is common to all cases in which it occurs—it is that no difficulty has ever been found in obtaining any amount of evidence of this description on either side of any point in issue. There is a contest as to whether a vitriol or a gas manufactory is a nuisance. Twenty chemists of fair character and scientific acquirements come forward to swear that the effluvia evolved by those processes are producing the most deadly fevers, and twenty others equally eminent will give just as positive testimony that the gasses are absolutely wholesome and rather fattening than otherwise. These things are of every-day experience.' . . . It can not be denied that experts have frequently introduced into their evidence speculative fancies and idle theories, not warranted by a proper induction from the facts; but it is quite clear that in all trials requiring special knowledge, if justice is to be administered, the court must be assisted by those who possess the knowledge. . . . The cause of the evil is that the solicitors on each side are allowed to search the whole profession until they can find one or more persons ready to adopt their respective views; and when once in court, provided a man can call himself a 'doctor,' his qualifications sometimes escape a rigid scrutiny. Persons have thrust themselves or been thrust into cases as experts without any pretensions to such a title either by their professional standing or experience. A man who may be engaged only in the ordinary routine of medical practice, and who may have had no special experience on the subject on which an opinion is required, will be described by his counsel as 'a most eminent member of the profession, on whose opinion the jury are as much entitled to rely as on that of the very respectable gentleman called on the other side,' etc. The nomination of experts as witnesses by the judge who tries a case, or by the lord chancellor in his department, would do away with most of the objections which now tell with so much force against the evidence of experts. As long as they can be retained by either party—and the profession is large enough to furnish a great variety of experts—so long will the objections to the present system continue and the good be confounded with the bad. But even men of professional skill and position sometimes give cause for censure. But the question regarding this employment of experts as assessors, and the avoidance of the imputation of their appearing as hired retainers in a case is practically in the admiralty courts. Four Masters of the Trinity House, experienced in all the rules of navigation, give their opinions on questions submitted to them as experts by the court; and without creating any charge of injustice in the decisions of the court, they constantly guide these decisions by answering certain difficult nautical questions. In a case in

which two ships come into collision, both parties contend they are right, or the case would not be litigated. The question turns upon the respective positions of the ships, the setting of certain sails, the direction of winds, tides, and currents, and whether the helm should have been ported or starboarded before the collision. These nautical experts, as their opinions are now received, acquit themselves with satisfaction; but if such a trial took place before a jury, and each captain were allowed to select his own experts as witnesses, there would be the same dissatisfaction as that which now exists in reference to trials involving other branches of scientific evidence."

"There can be no doubt that the present system discourages some eminent and upright men, who could by their special knowledge solve many important questions from appearing as witnesses. . . . As counsel on both sides look on the experts opposed to them in the light of hired advocates, it is obvious that so long as this system lasts it must have a deterring effect on the higher and better class of witnesses, who, whenever they have the option, will avoid placing themselves in such a position as to have imputations of venality and untruthfulness thrown out against them in a public court." 'It is a fact worthy of note that even in criminal trials where life is concerned no provision is made by the English law for the calling by a judge of independent medical witnesses or experts interested only in the manifestation of the truth."—*Taylor's Medical Jurisprudence.*

NOTE.—We have just received the new and enlarged London edition of this most valuable work, and shall continue from time to time to make such extracts as can not fail to interest the profession. The greater part of the above was copied from the *London Medical Times and Gazette* before the book was received.—G. C. B.

INSANE ASYLUM REPORTS.

Sixth Annual Report of Longview Asylum.

We are indebted to Dr. O. M. LANGDON, the able Superintendent of Longview, for a copy of his annual report. We extract the following:

Remaining at commencement of the year, 367. Received during the year 163. Discharged or died, 154. Remaining, 376. Total, 1,060.

Of those discharged there were, cured, 34 males, 55 females; improved, 11 males, 20 females; unimproved, 2 males, 1 female; died, 17 males, 13 females.

The percentage of cures on admissions was 52.20 against 57.50 last year.

He makes the following excellent remarks upon some of the causes of insanity:

"By comparing the report of this year with the last, you will find we have had an increase of the whole number treated of thirty-three. It was the opinion of many of the best and wisest medical men, that as a consequence of the excitement and calamities incident to a state of war, there would be a great increase in the number of insane, but happily such opinion has not been verified. Very few cases coming under our care could be attributed to such cause. On the contrary, indeed, it is the almost uniform testimony of physicians in general practice, that during all the four years of our dreadful conflict, diseases of the nervous system were less prevalent than before. By

others it was believed that when the war should end, and the sustaining excitement attending it had passed away, people would reflect more profoundly upon the calamities that had fallen upon the nation, and more especially upon themselves in the loss of relatives, friends, and property, and that then there would come more of grief, despondency, insanity. This, however, so far as we can perceive, is not being justified by the facts. That some have been made insane by the distresses and accidents of war is undoubtedly true, but the increase in the number of our inmates is owing, in the main, to the operation of more common causes. Prominent among these common causes, I feel it a duty to refer, in an especial maner, to the matter of the intemperate use of alcoholic stimulants. To one in health they are never beneficial, and are almost always pernicious in their effects upon both body and mind. Of 1,181 patients received here, 145 were insane from this cause alone.

"This bad influence of a bad habit was particularly manifest during, and more immediately subsequent to the rebellion, and gives additional confirmation to what has been observed in the history of all civilized nation, namely, that when any great calamity, whether of war, famine, pestilence, or monetary crisis, falls upon a people, they in large numbers take either to praying or drinking."

We observe some singular mistakes; for instance, Table I, in which "Died" is placed at the head of the third column, instead of "Total."

Ninth Annual Report of the Trustees and Superintendent of the Ohio State Asylum for the Education of Idiotic and Imbecile Youth, for the year 1865.

From the trustees' portion of the above report we learn that the legislature at its last session made an appropriation of fifty thousand dollars for the erection of permanent buildings for the institution, and at the same time authorized them to invite proposals for donation or sale of a site; and that in answer to such invitation "no donations whatever, either of lands or money, were offered," but plenty of offers to sell land were made. God help us! We remember when, a few years ago, the question of a new penitentiary was agitated, half the towns in the state were making the utmost exertions and the most liberal offers to secure it in their vicinity! Charity suggests that the invitation could not have been widely circulated, or that the absorbing public issues of the past few years prevented it receiving due attention; it can not be possible that the State of Ohio has within her borders no rich citizen who would give of his lands to this unfortunate, wretched, and helpless class of mortals.

The foundation of new buildings have been laid, and the amount appropriated by the state will be expended in erecting them.

From the report of the superintendent, Dr. G. A. Doren, we learn that about fifty pupils have been under instruction during the past year, and that the institution has been unfortunate in regard to the health of its inmates; spotted fever having made its appearance and carried off three pupils. An interruption of the course was thereby occasioned, which sadly interfered with the progress of the instruction. Still, "twenty-two have learned to read

and write since admission; sixteen of the others read short sentences, and are learning to write." But "an education from books" is not the chief object of instruction; it is a great task to teach many of this class even such lessons of personal cleanliness as will make them comfortable to themselves and no longer objects of disgust to others, and when taught a great triumph. This is clearly appreciated by the doctor, who writes like one devoted to his specialty, and well acquainted with its difficulties and the best means of overcoming them.

This institution is one of the few of the kind in the country; it has been in existence nine years, and the benefits it confers are matter of observation; certainly no class of the afflicted appeal more strongly to our sympathies, nor do any need more urgently special means for cure and instruction, for in the language of the report, "no truth is better established than that idiotic children can not be greatly improved in the family." We trust that Ohio will maintain the same proud preëminence in this, as she does in her other benevolent institutions. R.

Eleventh Annual Report of the Board of Trustees and Officers of the Northern Ohio Lunatic Asylum. Dr. Byron Stanton, Superintendent.

Remaining in the asylum, October 31, 1864, 61 males, 73 females; of these there were discharged recovered, 14 males, 20 females; improved, 3 males, 12 females; unimproved, 3 males, 4 females; escaped, 1 male; died, 3 males, 3 females.

Admitted during the year, 52 males, 54 females; of these there were discharged recovered, 9 males, 13 females; improved, 1 male, 5 females; unimproved, 3 males; escaped, 1 male; died, 5 males, 3 females.

Total number under treatment, 113 males, 127 females. Discharged, 43 males, 59 females. Remaining, October 31, 1865, 70 males, 68 females.

Twenty-seventh Annual Report of the Central Ohio Lunatic Asylum. Dr. Wm. L. Peck, Superintendent.

In the Asylum, November 1, 1864, 124 males, 141 females. Admitted during the year, 90 males, 98 females. Discharged during the year, 80 males, 94 females. Of those discharged, recovered, 37 males, 40 females; improved, 10 males, 17 females; unimproved, 21 males, 22 females; died, 11 males, 16 females. Percentage of recoveries of the total number discharged, 44.25; of total number admitted, 40.96.

Scientific Report on the Trichina.—The Prussian government had entrusted investigations on the nature and mode of propagation of the trichina to Prof. Kuhne, of Halle, and zealously were they pursued from 1863 to 1865. The report has been sent in, and states, among other things, the following particulars: Pigs affected with trichina do not present symptoms sufficiently obvious to be recognized by breeders. It was therefore incumbent on the reporter to elucidate facts connected with diagnosis. Animals were for that purpose fed with meat full of trichinæ, and daily watched by veterinarians.

The latter could hardly detect any change in the health of the animals, nor did slight indispositions present anything which could be construed into a pathognomonic symptom of the disease; yet it was proved by post mortem examination that trichinæ had formed in large masses in the muscles of the animals. Hence the breeder can not be expected to recognize the existence of the malady, nor should he be punished as having sold diseased meat. No difference of race, sex, or age creates a greater or less aptitude to be invaded by the trichinæ. It is not true, as has been asserted, that trichinian disease is produced by feeding pigs with beetroot, by the ingestion of earth-worms, or of moles containing trichinæ. The investigators have found that the parasites of the beetroot and the moles are not identical with the trichinæ which infest the pig. Not so, however, with rats and mice, which are sometimes devoured by pigs. Cats may also be contaminated; the latter are especially susceptible. It is therefore important to prevent pigs from eating dead animals. It is very likely that foxes and weasels may be very dangerous in this respect, but it is very plain that pigs can but seldom feed upon them. Dogs are very liable to breed trichinæ, but birds are quite unsusceptible. Trichinæ which have passed into the stomach of pigs with their food, are therein completely destroyed; hence it may be inferred that the fœcal matter of diseased animals is not noxious. The culinary precautions to be held in view when cooking pork are the following: The process of boiling or roasting should be carried on with the greatest care. People should not partake of any meat that has not been sufficiently cooked, and avoid such roast pork the center of which still presents traces of blood. By salting and smoking ham for about ten days, the trichinæ are quite destroyed.—*London Lancet, Feb.* 10.

Dr. Young's Field Observations in Surgery.—As has been already announced in the advertising sheets of our *Journal*, the enterprising house of Robert Clarke & Co., has issued proposals for the publication of a work by Dr. D. S. Young, to be entitled "*Field Observations in Surgery.*" We have carefully examined the collection of sketches made by Dr. Young, and have no hesitation in asserting that the work will prove of great interest and value to the profession. Dr. Young was connected with the army from the commencement to the end of the war, and sketched with his own hands many of the more important injuries and pathological appearances which came under his observation. His opportunities have been of no ordinary character, and we predict that the forthcoming volume will reflect credit upon the publishers, and redound to the surgical reputation of the Queen City. Dr. Young has kindly consented to continue a series of sketches and reports similar to those contained in the March number of our *Journal.* G. C. B.

Death among the Parsees.—Physicians who attend Parsee patients are always charged (if the cases are likely to terminate fatally), to give timely warning to the friends of the sick man. When it is believed that he is drawing near his end, the attendance of the physician is dispensed with, the dying man is given over to two Parsees attending, who divest him entirely of clothing and convey him to a chamber on the lowest floor, from which all furniture

has been removed, and in which there is nothing but two stones. The poor man is placed upon these stones, held up in a sitting attitude by one of the men, and his body is besmeared with cow's urine. If possible he must be made to drink some of the same; this is regarded as of great importance, and under the circumstances, of singular efficacy in fitting his spirit to appear before the Judge of all. After this a quantity of warm water is poured upon the poor man, one vessel full after another, and in the great majority of instances, the vital spark is extinguished at this time. We have heard of a case where a physician was summoned in all haste; before he reached the house, however, the friends of the sick man thought him to be on the point of death, and without waiting, removed him to the death-chamber. The doctor arrived and was told that the patient was dead. He asked to see him, but was denied access. He inquired regarding the symptoms, and on being informed of them, he declared his belief that the man was not dead and insisted on seeing him. But they would not allow him to approach the body; he might see it from a considerable distance. This ablution with the sacred element is regarded as a means of washing away their sin.—*The Times of India.*

Homœopathy and the Cattle Plague.

The doctrines of Hahnemann have been put upon trial in the cattle plague which is now raging to so fearful an extent, and have yielded no better results than other modes of treatment. As usual, their adherents entered the field with a great flourish of trumpets, and there was to be no end to the amount of good they would do; the result did not, however, justify their boasting. In one instance seventeen cases were placed under charge of three homœopathists, two of whom were veterinary surgeons, the sheds for the animals being provided with all appliances for regulating the temperature; eleven of the patients were dead at last accounts, and the others not expected to recover. In another case six animals only were alive on the 22d of the month out of thirty-six treated since the 1st. As animals can be so entirely controlled as to encountering any disturbing influences to the action of medicines so delicate and powerful (!!) as the homœopathic, we suppose this must be considered a very fair experiment.

Calabar Bean in Chorea.—Some interesting clinical observations have been made by Dr. Ogle, at St. George's Hospital, on the use of Calabar bean in chorea. The preparation he employed was a tincture, having the strength of one drachm of the bean to one ounce of rectified spirit of wine.

He relates two cases of marked improvement under the use of twenty to forty drops of the tincture three times a day.—*Medical Times and Gazette,* January 13, 1866.

The Jewish Hospital.—The Hebrew population of Cincinnati are distinguished for their enterprise and wealth, and largely have they contributed to architectural beauty of the Queen City. The new hospital just completed on the corner of Third and Baum streets is an ornament to the city. At the

inauguration ceremonies interesting addresses were delivered by the Rev. Dr. Lillienthal and Judge Storer. Mr. Abraham Aub is entitled to the highest praise for the zeal which he has displayed in bringing about the purchase of the present site and completion of the edifice. Dr. Rosenfeld, a highly competent physician, has, we believe, the medical supervision of the hos-

G. C. B.

Under the head of "To Correspondents," in the *London Lancet*, June 20, 1863, we find the following:

"According to the *Abeille Medicale* the earth is inhabited by 1,288,000,000 of people, viz: 368,000,000 of Caucasians, 552,000,000 of Mongolians, 190,000,000 of Ethiopians, 1,000,000 of American Indians, and 200,000,000 of Malays. The number of deaths per annum is 333,333,333, or 91,954 per day, a loss compensated by an equal number of births. The average duration of life throughout the globe is thirty-three years; but one fourth of the population dies before the seventh year, and one half before the seventeenth.

Uterine Surgery—Ode to Dr. Marion Sims.

Many of our readers have doubtless watched with interest the brilliant success of our distinguished countryman, Dr. Marion Sims, who for a few years past has been sojourning abroad. He has recently published a treatise on Uterine Surgery, which has been highly praised by the *London Lancet*. The notice of the *London Times and Gazette* we have not yet seen, but infer from the following that the latter journal has taken a less favorable view of the work. We insert the Ode, together with the preliminary remarks as they appear in the *Times and Gazette*, Feb. 24:

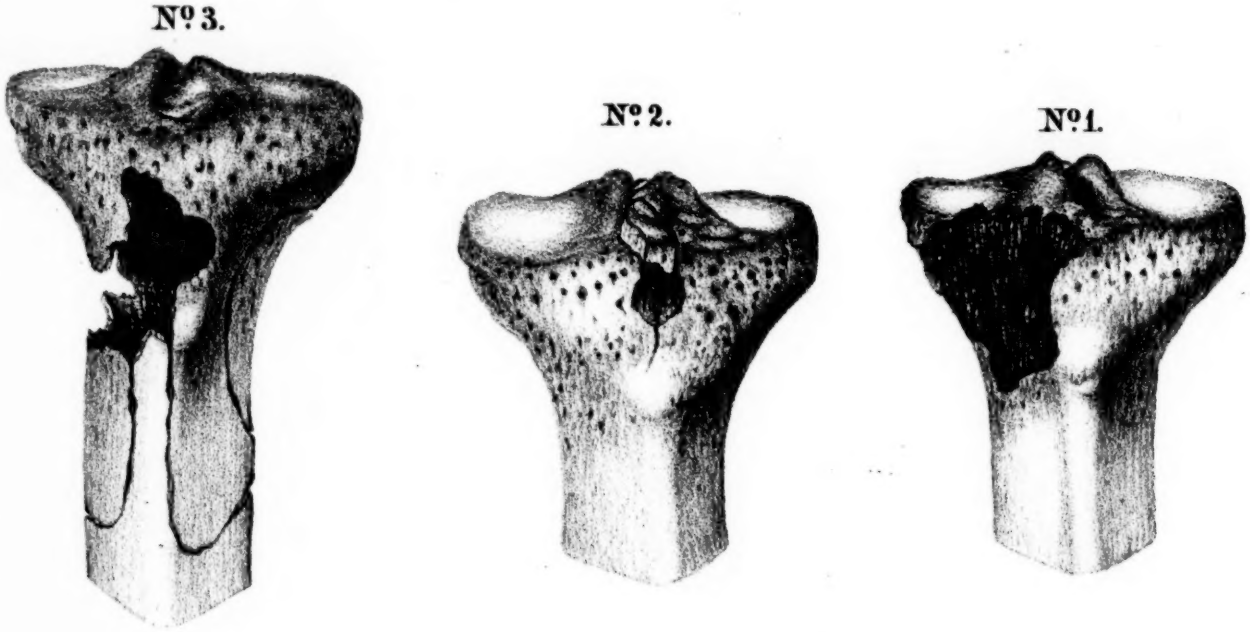
Sir—After reading your vigorous criticism on the recently published work of Dr. Marion Sims, my "teeming brain" conceived the following verses, which I hasten to deliver to you, to be, as you may think best, either strangled at once, or, happier fate! received among your adopted children.

I am, &c., H. L.

Say, what is man? An atom at the first,
  Waiting its nuptial atom in the womb;
Too oft, alas, by fate untimely curst,
  In place of fostering home, to find a tomb.
Grieved at the thought, a tear thine eye bedims,
Great son of Æsculapius, Marion Sims.

Swift to thine aid inventive genius brings
  Persuasive tent or glistening hystrotome;
With these, the obstructed portal open flings
  And guides the struggling spermtozoon home.
Thus may the wished for union perfect be—
The mystery no human eye can see.

Sims, should these fail, thou still wilt cherish hope
  To find some other cause that breeds the ill:
With learned digit, searching microscope,
  Or peering speculum, exploring still;
Nay, wizzard like, ethereal sleep will shed
To win thy point, e'en o'er the nuptial bed.


Nº 3.
Nº 2.
Nº 1.